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MEDICAL ALERT

A STAFF REPORT SUMMARIZING THE HEARINGS ON "THE FUTURE OF HEALTH CARE IN AMERICA"

PREPARED FOR THE USE OF THE

SUBCOMMITTEE ON EDUCATION AND HEALTH

OF THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

OCTOBER 2, 1989

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LETTER OF TRANSMITTAL

September 14, 1989.

Hon. LEE H. HAMILTON,
Chairman, Joint Economic Committee, Congress of the United States, Washington, DC.

DEAR MR. CHAIRMAN: I am pleased to transmit herewith a staff report entitled "Medical Alert."

The Report summarizes testimony received during nine days of hearings on The Future of Health Care in America. Testimony was received from 67 witnesses including physicians, hospital administrators, researchers, economists, government officials, health organization representatives, insurers and others with expertise in the area of health care.

The hearings were held in response to growing concern about soaring health care costs accompanied by diminished access to quality health care for millions of Americans. Among the issues addressed at the hearings were:

- Health care costs and trends;
- Demographic trends;
- Alternative payment methods for hospitals and doctors;
- The role of modern technology in health care delivery;
- Health care needs of the elderly;
- Innovations in health care delivery;
- Medical ethical problems; and
- Medical malpractice insurance.

The hearings were organized by David Podoff of the Committee staff. The Report was written by Deborah Matz with contributions from David Podoff and David Grinnell, all of the Committee staff.

The Subcommittee is grateful to Karen Davis, Professor and Chairman, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health; Uwe Reinhardt, James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University; and Linda Reivitz of the Joint Economic Committee staff for their valuable suggestions upon reviewing the manuscript.

We also wish to acknowledge the assistance of Suzanne W. Letsch, Actuary, Health Care Financing Administration, in generating tables and providing the Subcommittee with data, and Nancy Speights of the Joint Committee staff for enormous administrative assistance.

With every warm best wish,

Yours,

JAMES H. SCHEUER,
Chairman, Subcommittee on Education and Health.

CONTENTS

	Page
Letter of Transmittal	III
Introduction by Congressman James H. Scheuer	1
Summary and Recommendations	9
Access	11
Emergency Room Care	11
Women and Children	11
Medicaid Patients	12
Long-Term Care Patients	12
Other Access Problems	13
Health Care Needs of the Elderly	14
The Changing Age Structure	14
Long-Term Care	15
Costs of Long-Term Care	16
Moral Dilemma	16
Ethical Questions	17
Economic Pressures	18
Health Care Expenditures	19
The Health Care Dollar	19
Absolute Dollars	19
Growth Rates	20
Components of Change	22
Price Inflation	22
Gross National Product	24
International Comparison	24
Pluralism and Dysfunction	28
The Appropriate Use of Technology	30
Technology	31
Overutilization	31
Patients' Attitudes	32
Ethical Questions	33
Physicians' Fees	35
Fee-for-Service	35
Canadian Experience	37
Salary	39
Capitation	39
Fee-for-Episode	39
Hospital Costs	41
Efforts To Reduce Costs	41
Medical Malpractice Adjudication System	45
Impact on Health Care	46
Cost of Care	46
Access to Care	46
Quality of Care	47
Options for Change	48
National Health Insurance	48
Medicare Reform	49
Fee Schedule	50
Preferred Provider Organizations	50
Appropriate Use of Technology	51
Treatment Guidelines	51
Patient Attitudes	52
Research Needs	52
Health Prevention	52
The Elderly	53

Page

Options for Change—Continued
Care of the Elderly 54
Assessment and Management 54
Private Sector Role 54
Rationalizing Malpractice Liability 55
Changes/Alternatives to the Current System 55
Traditional Tort/Judicial Reform 55
Administrative Reforms 55
Ethical Issues 56
The Federal Role 56
Funding for Research and Assessment 56
Educational/Information Role 56
Medicare Rules 57
Agenda and Witness List 58

INTRODUCTION BY CONGRESSMAN JAMES H. SCHEUER

CHAIRMAN

SUBCOMMITTEE ON EDUCATION AND HEALTH

A healthy, well-educated population is essential to a sound, vibrant, productive national economy. However, the future of our economy seems to be in peril. An obsolete education system is contributing to the inability of the United States to compete effectively in the international economic arena. At the same time, the Nation's health care system, which costs $550 billion per year, excludes 37 million Americans, is woefully wasteful, cost ineffective, and a drain on the Nation's human and capital resources.

A healthy population, it hardly needs stating, is one of the Nation's most important resources. It provides workers who are more productive and who lose less time due to illness and injury; produces children who are more likely to succeed in school; and fosters senior citizens who lead full, rich, independent lives with less need for expensive health care and social services.

Thus, between May and June 1988, the Subcommittee on Education and Health, which I chair, held nine days of hearings and received testimony from over 60 witnesses in its examination of "The Future of Health Care in America." Among the issues considered at the hearings were:

- Health care costs and trends,
- Demographic trends,
- Alternative payment methods for hospitals and doctors,
- The role of modern technology in health care delivery,
- Health care needs of the elderly,
- Innovations in health care delivery,
- Medical ethical problems, and
- Medical malpractice insurance.

(The witness list and agenda can be found at the end of this Report.)

Based on this testimony, it is apparent that the health care system in America is a study in contrasts. The American health care system, one of the largest industries in the Nation, represents some of the very best and the very worst in the community of industrialized nations.

On the one hand, ours is the most innovative health system in the world, both at the clinical level and in terms of alternative modes of health care delivery. The rest of the world now looks to the United States as a giant laboratory whose products are sampled and adopted selectively. Virtually every industrialized nation in the world is now toying with the idea of using Diagnostic Related Groups (DRGs) for hospital reimbursement, for example, and

many nations seek to import our concept of the Health Maintenance Organization.

At the clinical level the United States also excels in many areas. We still remain, in many ways, the Mecca for the world. And no nation educates physicians more thoroughly than we do, even if we seem to produce the wrong mix of specialties.

In recent years great advances have been made in both health technology and treatments. Undoubtedly American health care has contributed to major improvements in health:

- Life expectancy of Americans has increased from 69.7 years in 1960 to 74.7 years in 1985;
- The incidence of some diseases, most notably polio, measles and mumps, have been drastically curtailed; and
- Development and availability of high-technology equipment such as CT scanners, ultrasound and magnetic resonance imaging, and new procedures such as organ transplants and kidney dialysis have assisted diagnosis and treatment and have extended life to people otherwise facing sure death, prolonged hospitalization or deteriorating quality of life.

On the other hand, however, for millions of Americans, health care is elusive. They are precluded from participating in this vast system because they are unemployed, or as is more typically the case, they have a low-paying job and simply cannot afford health insurance or have inadequate coverage. As implausible as it may seem, in this country, rich, not only in the sense of great wealth, but in a strong Judeo-Christian heritage based on fairness and equality, there are some 37 million Americans who are uninsured, 70 million more who are underinsured and 23 million who are served by Medicaid, who are not guaranteed access to or equity in medical treatment.

Poor, uninsured people who do receive medical treatment but cannot afford to pay, may even find themselves subject to law suits. Here in the District of Columbia's Small Claims Court, in a two-month period, 872 cases were brought by hospitals against individual defendants. Annualized, that is over 5,000 cases a year in just one jurisdiction. Obviously, hospitals, particularly those in poor areas, do not have the financial resources to provide treatment without reimbursement to every uninsured person in need of medical care. However, every American should have access to affordable, quality health care.

Thus, our health care system has created a moral dilemma with far-reaching implications. It separates rich from poor, young from old, healthy from frail in the provision of health services. Witnesses testified about poor pregnant women who have no access to prenatal care and about the one-third of the near-poor elderly who are reduced to poverty by out-of-pocket payments for medical care. They spoke of those poor who are fortunate enough to have access to municipal emergency rooms and who must use them for routine treatments. They spoke of how preventive care suffers under these conditions and the toll this takes on emergency room capacity and budgets, as well as their all-around cost effectiveness in delivering differing types of health care, including some for which they assuredly were not designed. And they spoke about the poor who are not so fortunate; who live in cities like Miami or Houston where

one municipal hospital serves an entire jurisdiction. In these areas health care for the poor is as elusive as the American dream.

These hearings were held to consider likely future health needs and policies based on current and emerging demographic and expenditure trends.

1. Demographics: The U.S. population is aging. Currently 12 percent of the population is 65 and over. It is estimated that by the year 2050 almost one in four people will be at least 65 years old and of those about 20 percent will be aged 85 and over compared to 10 percent today.

2. Expenditures: In 1950, the Nation spent $12.7 billion on the health sector; by 1988, national spending was over $500 billion. As a share of the GNP the United States spends more than virtually all other industrialized nations. In 1985, for example, the percent of gross domestic product spent by members of the Organization for Economic Cooperation and Development (OECD) averaged 7.3, compared to 10.7 for the United States. The U.S. share of GNP devoted to health care increased from 4.4 percent in 1950 to 11.5 percent in 1988. These trends are projected to continue at an accelerated pace through the end of the century.

Notwithstanding these astronomical national health care costs, Karen Davis, Professor and Chairman, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health, advised the Subcommittee that, "While the United States has experienced major improvement in the health status of its people, many question whether health spending is yielding commensurate benefits in terms of improved health or quality of life for Americans." Following are some of the most significant concerns raised at the hearings:

1. Health care costs continue to soar. In 1950, the Nation was spending a billion dollars every month on health care; by 1988, it spent a billion and a half dollars a day.

2. Thirty-seven million Americans have no insurance. Sixty percent of these are women of child-bearing age or children. Another 70 million are underinsured.

3. One-third of the near-poor elderly are reduced to poverty by their out-of-pocket payments for medical care, including long-term care.

4. Twenty to thirty percent of medical procedures which are performed—x rays, tests, drugs, surgery and the like—may not be warranted.

5. Treatments for the same diagnosis vary widely from one jurisdiction to another. For instance, residents of New Haven are more likely to have coronary bypass operations, hysterectomies, and back operations than Bostonians and Bostonians are much more likely to have their hips and knees replaced.

6. Americans are far more likely to undergo surgery than are Europeans. We are four times more likely than the British to have coronary bypass operations, and twice as likely to have prostatectomies and hysterectomies, for example, with little or no differences in health outcomes.

7. The current cost of health care in the United States could be cut drastically by:

a. Eliminating wasteful procedures. $125 billion in unnecessary tests and treatments can be cut from the system without affecting quality;

b. Reducing paperwork. The U.S. health care system is the most bureaucratic in the world. The paperwork created by our pluralistic system adds a $20 surcharge for each $100 spent on health care;

c. Changing lifestyles to prevent certain disorders. Information to reduce and/or prevent certain conditions is at hand. Simply implementing what we already know—changing behavior and providing preventive primary care to all—would go a long way toward reducing our health care costs. For instance, of the 2 million deaths in the United States every year, about 1.5 million are due to heart disease, cancer, stroke, or fatal injuries. Preventing these conditions—by quitting smoking, improving diet, exercising, wearing seat belts, moderating intake of alcohol, and eschewing legal and illegal drugs—would save over $200 billion a year in health care costs and lost wages.

8. Almost 60 percent of all deaths in the United States are premature and a similarly high level of disabilities and illness can be avoided. Yet, at best only 4 percent of health care expenditures is for health promotion and disease prevention (including counseling) and this figure could be as low as 0.3 percent.

9. Arthritis, incontinence, and dementia are the three major causes of dependency and immobility in the elderly ensuring confinement and long-term care, yet research in these areas receives minimal funding.

It is apparent that, based on demographics, our future health care needs will increase significantly as the population ages. If no changes are made, what are currently looming concerns could well be come a pressing crisis as baby boomers become senior citizens and senior citizens become octogenarians, nonagenarians, and centenarians in unprecedented numbers. People aged 85 and over will comprise a much larger percentage of our population in the coming years than they do today and the elderly will consume a far greater proportion of our health care dollars. Thus, we can expect a twofold to threefold rise in the use of physician and hospital services and a fourfold increase in the use of long-term care facilities by the year 2040.

Unlike other Western industrialized nations, in America, health care is a privilege not a right. It is costly. It is inefficient. Access is not universal. Programs to protect the poor are ridiculously complicated, rigid, and inadequate. As we move toward the 21st century and our population keeps aging, bold and immediate steps must be taken if interclass and intergenerational conflict are to be averted.

Rationalizing our health care system will be costly and complex in the short run. Not to do so, however, is even more costly—in terms of dollars spent, human suffering, and even our international competitiveness. For example, health insurance for employees, retirees, and their dependents cost General Motors $3 billion last year; that amounts to some $600 added to the cost of each General Motors vehicle as a direct result of exorbitant health care costs. This is a grossly cost-ineffective component of automobile production costs in a global economy.

While not all the witnesses agreed on every proposal, throughout the hearings certain recommendations clearly emerged:

I. First and foremost, it is apparent that national health insurance, in some form, must be implemented to assure that all Americans have access to high-quality, affordable health care. Of all Western industrialized countries, only the United States and South Africa do not provide universal access to health care. Our current patchwork of programs has resulted in a system which precludes millions of Americans and affords unequal treatment to those it accepts if they happen to be poor or underinsured. All Americans must be afforded access to high-quality health care and must be protected from devastating health care costs.

II. In the interim, Medicare must be reformed. The current system is inordinantly complex and costly. It is virtually incomprehensible to patients and physicians alike with payments calculated separately for each of the Nation's 325,000 office-based physicians for over 6,000 different procedures. The system is unwieldy—Medicare now must review and pay bills for over one-half billion Part B (physician) services annually—but also it encourages specialized procedures because they are compensated at a relatively higher rate. And sometimes these procedures are unnecessary.

Implementing a fee schedule, as proposed by the Physician Payment Review Commission, would promote a more appropriate, efficient, and equitable allocation of medical services and resources.

In addition, use of Preferred Provider Organizations (PPOs), should be encouraged. Under this approach, physicians who meet cost, volume, and quality expectations would be sought out for Medicare beneficiaries. The beneficiaries who choose to use PPOs would pay a smaller share of the bill than those who do not.

III. Regardless of payment source, standards of care based on outcomes research must be developed and applied by the health care community. Twenty percent of all tests and treatments—amounting to over $125 billion—may be unnecessary. In some instances, technology is used in ignorance or for a marginal benefit to the patient or in the absence of any credible evidence of its value. Further, patients with the same affliction may receive different treatment in different parts of the country. Establishing clear treatment guidelines could lead to reduced costs with no reduction in quality.

IV. Patients' attitudes must be changed. Patients have come to judge physicians by how much the physicians do to them. Patients must understand that not all treatments are associated with cures, and that there is not a clearly indicated remedial treatment for all illnesses.

V. Perhaps most important, Americans must be made to realize the importance of preventive life styles to the prospect for improved health. The role of physicians in achieving this goal, through patient counseling, cannot be overstated. Nearly 60 percent of all deaths that occur each year in the United States are premature. The estimated economic cost of *preventable* heart disease and stroke, cancer, and accidents is over $200 billion. To reduce these costs and prevent premature deaths and disabilities, Americans must be encouraged to stop smoking, control drinking,

eschew legal and nonlegal drugs, stick to proper diets, exercise regularly, learn to handle stress, and have regular checkups.

VI. This means, in effect, that the focus of the Nation's health care system must be changed from sickness care to wellness promotion. This involves a shift of focus from sickness care high technology such as organ transplants, coronary bypass procedures, kidney dialysis to low technology wellness care which includes drug, alcohol, and nutrition counseling as well as preventive tests and screening for hypertension, heart disease, and cancer.

Maintaining good health through counseling, testing, and preventive measures is enormously cost effective and life enhancing. Wellness clinics or primary care clinics, for example, should be located where they are most accessible—at the worksite, in schools, shopping centers, senior citizen centers, and the like. Use of such facilities for preventive care not only would save money in the long run for Medicare, Medicaid, and private insurers, but also would improve the health status of American citizens.

VII. Research priorities must be dramatically reordered. Medicare research must be directed to an area of great potential payoff: problems afflicting our Nation's elderly. While incontinence, memory loss, and immobility are the three greatest threats to the independence of the elderly, producing annual health care costs of about $60 billion, only about $200 million is spent on research to cure or eliminate them or lessen their debilitating impact. Particularly with the continuous graying of America, maintaining mobility and independence for the elderly would go a long way toward curbing the enormous anticipated increase in future health care costs.

Further, at best, only 4 percent of national health care dollars are spent on health promotion and prevention services. Additional research into the effectiveness of health promotion and disease prevention programs is imperative.

VIII. Our system of malpractice liability insurance must be rationalized. Malpractice premiums have skyrocketed in recent years. These increased costs to physicians have not only added to the cost of health care—16 percent of the increase in physician fees and another $10 billion per year for practicing defensive medicine—can be attributed to increased liability premiums—they have also had a severe impact on the availability of certain types of physicians. It is reported that 44 percent of the counties in Georgia, 42 percent of the counties in Alabama, and 30 percent of the counties in Colorado no longer have any physicians (obstetrician or family practitioner) providing obstetrical services. Further, almost 30 percent of obstetricians are restricting the percent of their practice devoted to high-risk pregnancy.

Administrative and other out-of-court dispute settlement mechanisms must be used to resolve malpractice liability cases. Such procedures should ensure that physicians are not charged excessively high insurance premiums and patients are neither denied an opportunity to redress their grievances for grossly negligent or incompetent physician behavior nor denied urgently needed health services such as obstetrics and brain surgery.

IX. Finally, the Federal Government must assist in promoting ethics education, setting standards for advance directives (living

wills and the like), and modifying Medicare payments to reimburse palliative care for the dying. Due to increased life-extending (not enhancing) technology and longer natural lifespans, increasing numbers of people are confronting questions of whether to accept, refuse, or withdraw from life-sustaining treatments, either for themselves or for others.

Simply spending more on health care is not—nor should it be—an option. The United States currently spends a far greater proportion of its GNP for health care than any other industrialized country. Yet, our system does not guarantee access to all Americans and the United States lags many other nations on several important health measures. For instance, of the 22 OECD members, the United States ranks first in health care spending, yet only 8th in life expectancy and an embarrassing 20th in infant mortality.

Further, other urgent social needs compete with health care for limited budget dollars. Each additional dollar spent on health care, is a dollar which might have been spent on Head Start, education, infrastructure, research and development, or housing for the poor. Overhauling the health care system by significantly modifying the existing system in the short run and by ultimately providing national health insurance will not only rationalize health care delivery but will also save billions of dollars which can be used to finance other national priorities.

Becoming a happier, healthier, more productive nation is within our grasp. It requires, however, a strong national commitment to change and the national will to make difficult choices and to live with the consequences: vastly expanded access and improved quality for many accompanied, perhaps, by somewhat less choice, fewer treatments or procedures and possibly fewer health care jobs and lower salaries for some physicians.

As witnesses told the Subcommittee, the American preference for choice, procedures, tests, and for an abundance of high-tech equipment drives our health care system to push up the costs. We, as a nation, can no longer afford such wasteful indulgence. Overhauling our health care system will go a long way toward enhancing and protecting the living standard for all and improving individual well-being for many.

The report which follows, written by Deborah Matz of the Joint Economic Committee staff, analyzes some of the major problems in health care delivery. These include problems of access, health care needs of the elderly, ethical questions, and cost. The cost section considers the effects of pluralism and dysfunction, physician fees, hospital costs, overutilization of technology, and malpractice liability insurance.

On behalf of the Subcommittee, I would like to acknowledge the outstanding job Ms. Matz has done in summarizing the enormous quantity of testimony we received on this subject. She is to be commended for organizing and writing a splendid report which helps to simplify an extremely complex issue.

The Subcommittee is also grateful to David Podoff of the Joint Economic Committee staff for his fine efforts at organizing such a thorough and useful set of hearings.

SUMMARY AND RECOMMENDATIONS

America spends far more on health care than do other industrialized countries and costs continue to escalate at a rapid pace. Costs are driven up by a wide variety of factors including:

- Excessive waste;
- Overutilization of technology;
- Skyrocketing malpractice insurance premiums;
- Patient attitudes that more tests and procedures are better than less; and
- A pluralistic approach in which wide ranges of choice on all aspects of health care are considered essential.

While our costs are excessive, quality health care is neither universally available nor of uniformly high quality. Our health care system offers the best to some. To others, namely the poor, unemployed or those who do not have adequate insurance, health care may be extremely difficult to obtain or nonexistent, and sometimes of questionable quality. Witnesses agreed that we need to begin to respond to our changing demographics. Per capita personal health care expenditures are drastically higher for the elderly than for the rest of the population. This is in large part because long-term care is the most frequent and common health care need of the elderly. Long-term care is so expensive, however, that one-third of the near-poor elderly are reduced to poverty by out-of-pocket health care costs.

Witnesses described a system characterized by extraordinary waste. As much as $125 billion per year or $1 out of every $4 spent on health care is wasted. They spoke of excessive tests being administered, of health problems being treated differently in different parts of the country and of procedures of all kinds—tests, operations, treatments—being performed without any benefit to the patient's health.

Witnesses detailed the effect of skyrocketing malpractice insurance premiums. Not only have certain high-risk specialty practices been discontinued or curtailed but increased premiums have driven health care costs up by 16 percent in a two-year period. This, in addition, to the costs for defensive medicine which adds $10 billion to our health care bill each year.

Finally, witnesses recounted the many obstacles present to dying with dignity. Witnesses widely agreed on the right of patients to accept, refuse, or withdraw from treatment, even if the action will likely result in the patient's death.

The 68 witnesses who testified before the Subcommittee represented physicians, hospital administrators, researchers, economists, government officials, health organizations, insurers, and others with expertise in the area of health care. Many of the witnesses agreed upon a number of recommendations:

1. National health insurance, modeled after the Canadian approach, would ensure all Americans access to high quality, affordable health care.

2. In the short term, Medicare reform—such as introduction of a fee schedule—must be adopted to curb excessive costs and simplify the complex Medicare reimbursement system. Preferred Provider Organizations and Health Maintenance Organizations are yet another avenue to reducing Medicare costs.

3. Standards of care based on outcomes research must be developed and applied by the health care community to limit unnecessary tests and procedures.

4. Patients' attitudes must be changed. Patients must learn that not all procedures and/or treatments are cures and that they have a responsibility for maintaining their own health. Patients must not expect to be "treated" for every condition.

5. Americans must realize the importance of preventive life styles to improved health. The role of the physician in achieving this goal, through patient counseling, cannot be overstated. Millions of lives and billions of dollars could be saved if Americans would stop smoking, control drinking, eschew legal and nonlegal drugs, stick to a proper diet, exercise regularly, learn to handle stress, and have regular checkups.

6. The health care system must change from sickness care to wellness promotion. Drug, alcohol, and nutrition counseling as well as preventive tests and screening for prevalent diseases should be conducted routinely. Wellness clinics or primary care clinics should be located where they are most accessible—at the worksite, in school, shopping centers, senior citizen centers and the like—would maximize the use of such facilities for preventive care and would improve the health status of Americans.

7. Research priorities must be changed. Health promotion and disease prevention and problems afflicting the elderly, such as arthritis, dementia, and incontinence, must receive greater attention.

8. Our system of malpractice liability insurance must be rationalized. Alternative methods of resolving malpractice cases must be utilized.

9. The Federal Government must assist in promoting ethics education, setting standards for advance directives (living wills and the like) and modifying Medicare payments to reimburse palliative care for the dying.

ACCESS

Paul G. Rogers, former Chairman of the Health and Environment Subcommittee of the Interstate and Foreign Commerce Committee of the U.S. Congress and cochairman of the National Leadership Commission on Health Care, stated that a goal of the American health care system "should incorporate access for all to an adequate level of care with cost-effective delivery of services, and appropriate, effective, and high quality care."

Emergency Room Care

Currently, however, 37 million Americans do not have health insurance and some 70 million more are underinsured. For many of these Americans, the hospital emergency room is the only available source of health care. As a result, many emergency rooms are used for nonemergency matters with resulting strains on personnel and facilities. Annette Choolfaian, Executive Vice President, St. Luke's Roosevelt Hospital Center, advised the Subcommittee that for the poor, "almost all the family doctor work is done through the emergency room."

Emergency room health care, however, does not provide for routine examinations or preventive health measures. And, as Margaret C. Heagarty, M.D., Director of Pediatrics, Harlem Hospital Center, pointed out, in some parts of the country even access to emergency room care is very limited. In Miami, for instance, there is only one public hospital for the entire metropolitan area and Houston has only one public hospital which serves the whole city.

Dr. Heagarty advised the Subcommittee, "if you live in suburban Houston and you're poor or you're an illegal alien, you're going to have a devil of a time getting prenatal care."

Even when public hospitals are available, as they are in New York City, access is still problematic for preventive treatments and care, and for prenatal examinations despite the fact that some public hospitals provide clinics for such services. Public hospitals tend to be understaffed and underfunded. As a result, it often takes weeks to get an appointment at a clinic and it is not unusual for patients to have to wait hours before being seen by a physician. In Cook County Hospital, in Chicago, Illinois, for instance, pregnant women often wait as long as nine weeks for clinic appointments and then must plan on waiting all day to see a physician. This is sufficient to discourage pregnant adolescents, among others, from seeking medical assistance.

Women and Children

Of those Americans who are uninsured, 60 percent are children or women of childbearing age, posing a grave threat to existing and future generations. According to Dr. Heagarty:

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> . . . the data are quite clear, women without health insurance delay or do not get prenatal care. And the data are equally clear, early participation in prenatal care and good obstetrical care will reduce infant mortality rates . . . and the rate of low birth weight infants. And every time we reduce the numbers of low birth weight newborns, we also reduce the number of chronically ill children who suffer a variety of handicapping conditions.

Prenatal health care is not only humane, it is very cost effective. Prenatal care costs about $600 per pregnancy. However, keeping a low birth weight baby alive costs $350,000 for four months in intensive care and "inestimable costs later for children that survive with handicaps," according to Seymour Perry, M.D., Deputy Director, Institute for Health Policy Analysis, Georgetown University Medical Center.

Dr. Heagarty identified those women with limited access to health care as:

> . . . immigrants . . . frightened to reveal their existence to authorities, or women who work in the marginal service jobs that have no unions and therefore no fringe benefits, they are the domestics who clean the middle class homes or care for the middle class children, but who work "off the books" and have no health insurance, they are the wives of the gypsy cab drivers or the filling station gas pumpers . . . . [T]hey are the wives whose husbands have lost their jobs because of economic recession or dislocation. . . . They are often just making it, but they have not given into the welfare mode.

Medicaid Patients

It is not only childbearing women and children who are excluded from the system. In 1965, Medicaid was designed as a medical "safety net" for the poor. However, Dr. Heagarty charges that the program has faltered in its stated goal of coverage to all of the disadvantaged. Medicaid has not been extended to some 12.6 million citizens who live below the poverty line. In fact, the percentage of the poor covered by Medicaid has fallen dramatically since 1976 when it covered 65 percent of poor families. By 1984, only 38 percent of the disadvantaged were covered by Medicaid.

Even those covered by Medicaid are not assured access to quality or timely care. Because the enrollment process is so long, according to Dr. Heagarty, pregnant Medicaid patients frequently do not receive medical assistance until they are in their second or third trimester. Medical care in the first trimester, however, is crucial to the development of healthy fetuses and babies.

Long-Term Care Patients

John Holahan and Korbin Liu, Director and Senior Research Associate, respectively, at The Urban Institute's Health Research Policy Center testified that it is not just access to preventive and acute health care which is limited. Access to the U.S. long-term care system is also limited for low-income and heavy-care patients.

Because in some areas nursing home beds are in limited supply, Messrs. Holahan and Liu argue, "it is difficult for Medicaid patients to obtain access in [communities] with fewer beds; in contrast, private patients face no access problems anywhere." They explained:

> In a market with fewer beds, nursing homes can choose the patients that are more profitable. The evidence overwhelmingly suggests that they choose either private-pay patients or Medicaid patients with more limited care needs. Heavy-care Medicaid patients and Medicare patients are less likely to be served.

Health care is elusive, at best, for the poor covered by Medicaid. It is virtually nonexistent for the millions of uninsured Americans who are not covered by Medicaid, and/or who do not live in close proximity to a public hospital.

Other Access Problems

It should be noted that testimony received at the hearings focused on the problems of limited access to discrete parts of the health care system: maternal and child care, emergency room treatment of the poor and uninsured, and long-term care of the poor and near-poor elderly. While they were not discussed in the testimony, some of the pervasive effects of access problems warrant mentioning. These include but are not limited to the following:

- Uninsured patients have been found to have high rates of untreated hypertension and diabetes and to be much less likely to seek care when they have serious symptoms such as bleeding or loss of consciousness;
- Blacks receive care for cancer at much later stages of disease than whites and have lower survival rates;
- Many communities suffer from a shortage of physicians. Community health centers are facing increasing difficulties attracting medical staff with the elimination of the National Health Scholarship Program;
- Rural hospitals are facing serious financial difficulties; and
- AIDS patients are shunned by private insurance companies and many health care providers.

HEALTH CARE NEEDS OF THE ELDERLY

If our current population had the same demographic mix that we expect to have in the year 2040, our Medicare costs would have been double what they are currently, and Medicaid expenditures for nursing homes alone would have been $75 billion instead of the $10 billion spent in 1986. As a result, our national debt would have been $150 billion greater just due to the increase in health care costs for the elderly, according to L. Gregory Pawlson, M.D., Director of the Center for Aging Studies and Services and Chairman of the Department of Health Care Sciences, George Washington University.

The Changing Age Structure

John G. Keane, Director, Bureau of the Census, U.S. Department of Commerce told the Subcommittee, "A growing, very old population is a reality in America. . . . As a nation, we will be much 'older' in the next century. Consequently, the nature of American society will be vastly different from today's."

Both witnesses were referring to the fact that the current population of older Americans, some 28 million persons aged 65 and older, is expected to increase to 39 million by the year 2010 and to 67 million by the year 2050. As a percent of the population, persons 65 and over will increase from about 12 percent today to over 20 percent by the year 2050.

Equally important is the point raised by Michael C. Carozza, Deputy Commissioner for Policy and External Affairs, Social Security Administration, that the elderly population itself is aging. He pointed out that the population aged 85 and over represents about 10 percent of those aged 65 and over today. However, by 2050, about 20 percent of the people aged 65 and over will be 85 and over. Thus, persons aged 85 and over will comprise about 8 percent of the population aged 20 to 64 in the year 2050, compared to 2 percent today. Mr. Carozza concludes that:

> Because of the relatively higher health care utilization of those at ages 85 and over, this redistribution of the aged population toward more advanced age will further tend to increase health care expenditures beyond that suggested by the increases in the aged dependency alone.

In other words, because people aged 85 and over consume a disproportionate share of health resources, and because they are an increasing proportion of the Nation's population, greater health care expenditures should be anticipated. In fact, per capita personal health care expenditures are four times greater for persons over 65 as they are for those under 65. And persons over 85 spend twice as much per capita as those age 65–69.

Dr. Pawlson predicted that based on demographics, "we face a twofold to threefold rise in the use of hospital and physician services and a nearly fourfold rise in the use of long-term care services by the year 2040."

Robert H. Binstock, Professor of Aging, Health and Society, School of Medicine, Case Western Reserve University, advised that regardless of what happens to health care in the years ahead, "the changing age structure within the older population will, in itself, have a substantial impact upon the nature and volume of the demand for acute care, and the resources necessary to respond to it." He explained that presently 45 percent of all health care spending on persons aged 65 and older in the United States is expended on hospitals but the differences in hospital utilization rates among age groupings within the older population are substantial: persons aged 75 to 84 and those 85 and older use hospitals 69 percent and 113 percent, respectively, more than those aged 65 to 74.

Long-Term Care

Mr. Binstock further described the differential impact on the health care system and health care costs of an aging population by considering long-term care needs. At present, about 2 percent of persons aged 65 to 74 are in nursing homes, compared to 7 percent of those 75–84 and 16 percent of those 85 and over. He estimates, therefore, that the current nursing home population of 1.5 million persons will increase to 2.1 million by the year 2000 and reach 4.4 million by 2040. This does not include the millions of noninstitutionalized persons who will be severely disabled but not in nursing homes.

Long-term care is the most frequent and common health care need of the elderly. According to Dr. Pawlson, it is almost certain that the period before death for most of us will be preceded by a period of chronic illness and functional decline.

Joseph Califano, former Secretary of the Department of Health, Education and Welfare cited the three main threats to the independence of the elderly as incontinence, memory loss and immobility.

- Incontinence: In 1987, more than $8 billion was spent to care for 500,000 incontinent people in nursing homes.
- Severe dementia: Americans spend $40–$50 billion a year for elderly victims of dementia which severely afflicts some 1.5 million Americans and moderately afflicts another 5 million others.
- Immobility: About $3.5 billion is spent treating the 15 million elderly Americans who have arthritis.

These ailments are particularly debilitating for the very old. Jacob A. Brody, M.D., Dean, School of Public Health, University of Illinois at Chicago, elaborated on the causes of these medical problems of the elderly and urged that we shift our medical research attention to the diseases and conditions of high prevalence in the eighth, ninth, and tenth decades:

1. Hip fractures: There are about 225,000 hip fractures in the United States annually. Half the hip fractures occur after age 79.

By the year 2000, we can expect 350,000 hip fractures a year and by the year 2020 more than 500,000.

2. Alzheimer's disease: There are in excess of 2.6 million patients with Alzheimer's disease. Half the Alzheimer's disease cases occurs after age 80. By the turn of the century, there will be almost 4 million people with Alzheimer's disease and by 2020 almost 5 million.

Despite the widespread need for long-term care, witnesses testified that long-term care in America has serious shortcomings.

Costs of Long-Term Care

Perhaps the most disturbing aspect is the financial cost to the patient. By far the most devastating health care expense for older Americans is that of long-term chronic illness. Nursing home stays account for over 80 percent of the expenses incurred by older people. Total nursing home care costs were $33 billion in 1988 and are expected to triple by 2018, according to Joshua M. Wiener, Senior Fellow, The Brookings Institution. Only a trivial portion of total long-term care bills (less than 3 percent) are covered by any form of insurance—Medicaid or private.

According to John Holahan and Korbin Liu of the Urban Institute, in 1985, Americans spent $19.8 billion directly out-of-pocket on long-term care expenses. Medicaid accounts for over 70 percent of government spending on long-term care but since it can only be used by patients who are poor, millions of Americans must "spend down" their income and assets to levels that make them eligible. With the annual cost of nursing homes at about $25,000, it is not surprising that one-third of the near-poor elderly are reduced to poverty by their out-of-pocket payments for medical care. Yet the care received by Medicaid patients is not necessarily comparable to the care which private paying patients receive. Because Medicaid reimbursement rates are below rates charged private-paying patients, Medicaid patients, according to Mr. Wiener, tend to receive lower quality care and often find an inadequate supply of services and encounter long waiting lists for admissions.

Moral Dilemma

Health care for the elderly has created a moral dilemma for the Nation. The United States has relied for long-term elderly care on a patchwork system of private out-of-pocket spending and Medicaid, a means-tested program. This system has not been successful in providing quality care to the elderly poor and has, in fact, created equity problems of its own. In addition, it has forced millions of Americans into poverty paying for long-term care before public assistance becomes available.

As a result, because few people can afford extensive long-term care and because the very poor are protected under Medicaid, "those most at risk of financially devastating expenses are middle income families who must deplete their savings of a lifetime in order to afford care," warned Marilyn Moon, Director, Public Policy Institute, American Association of Retired People [AARP]. The American system, thus, robs our elderly frail of dignity and self-worth along with their independence.

ETHICAL QUESTIONS

Decisions about whether, or how aggressively, to treat seriously ill newborns or terminally ill elderly are not and have never been easy. As Ann Neale, Vice President, Bon Secours Health System, Inc., pointed out, there are simply no answers or formulas which can be given in advance. However, due to longer life spans and advances in medical technology permitting extraordinary life-sustaining measures, increasing numbers of people will be forced to confront the question of whether to accept, refuse, or withdraw from life-sustaining treatment, either for themselves or—as surrogate decisionmakers—for others.

Mr. Morris B. Abram, Attorney and former Chairman of the President's Commission for the Study of Ethical Problems in Biomedical and Behavioral Research, focused the Subcommittee's attention on this dilemma:

> . . . Many of us believe we must marshall our resources for as long as possible to fight off our inevitable death. We seem to have lost sight of the concept, once a goal of all of us for our loved ones, of death with dignity. We must begin to understand that death is not always to be fended off.

Unfortunately, attaining "death with dignity" is made more difficult by the clinical decisionmaking process which often does not recognize the patient's "right to die," according to Susan Wolf, Associate for Law at the Hastings Center, an independent research institute specializing in medical ethics:

> . . . the right of patients to refuse treatment even if the expected consequence is death . . . remains more fiction than reality.

Witnesses widely agreed that a consensus among medical ethicists recognizes the right of patients to accept, refuse, or withdraw from medical treatment, even if this action is likely to result in the patient's death. This assumes that patients are competent to make such decisions: i.e., they understand their options; they understand the implications of whatever course of treatment they choose; and they are able to make and to communicate their decision. In addition, this consensus supports the use of advance directives (i.e., living wills or power of attorney on health care) by individuals to specify their wishes regarding medical treatment in case they become unable to make health-care decisions.

Mr. Giles Scofield, Staff Counsel, Concern for the Dying, echoed these sentiments, stating that:

> . . . these principles have been endorsed and elaborated on by numerous court decisions, professional organizations, and reports. . . . Despite these achievements, patients and

their families suffer from the immense gap that separates what the law permits from what doctors do.

Witnesses testified that a variety of obstacles hinder patients from fully exercising their decisionmaking prerogatives:

- Physicians' ignorance of the law and fear of medical malpractice liability;
- Patients' lack of information on their options, especially on advance directives;
- Disparties in and complexities of State laws governing advance directives;
- Lack of institutional policies on ethical issues;
- Economic pressures on the individual, family, and society; and
- Difficulties in obtaining palliative and hospice care, which often frustrate the wishes of patients seeking death with dignity.

Making critical decisions on medical treatments for those who are unable to make such decisions and who have not specified their wishes via advance directives raises the most serious ethical questions, particularly if the patient is deemed incompetent. While some States authorize family members to make decisions for incapacitated adults, court appointed surrogates are advocated by some interested parties.

Economic Pressures

Ms. Wolf contended that economic pressures loom large in the minds of health-care professionals. Because there is little consensus on how to handle these pressures, there is a risk of "bedside rationing," which she defined as ". . . the health care professional's taking matters into his or her own hands and rationing or cutting costs in an *ad hoc,* undisciplined way. . . ."

This is inappropriate and dangerous, argued Ms. Wolf:

> . . . If we are going to engage in rationing care, that must be accompanied by a full and public debate and be conducted through explicit policy at the institutional or governmental level. We cannot leave individual practitioners to engage in silent rationing according to principles that may be utterly misinformed and never exposed to public scrutiny.

Economic pressures also play a role in the types of care that are funded through most health insurance and through Medicare and Medicaid. Joanne Lynn, M.D., Acting Director, Center for Aging Studies, George Washington University, noted that the lack of funding for palliative care causes considerable difficulty in easing the pain of patients who wish to refuse or halt life-sustaining treatment:

> . . . The needs of dying patients are largely not covered by health insurance, including Medicare . . . . Relief of physical symptoms is often unavailable because the needed services are not reimbursable and because so few caregivers know the techniques needed. Supportive services are rarely a part of potential interventions.

HEALTH CARE EXPENDITURES

"Health care is devouring . . . an ever-increasing share of our national wealth." This assessment was presented to the Subcommittee by Joseph Califano, an attorney and former Secretary of the U.S. Department of Health, Education and Welfare. By every measure—absolute dollars, share of GNP, growth rates, and international comparison—health care costs have been spiraling in recent years. This section considers trends in total expenditures as well as trends in the components of these cost increases. Among these are pluralism, waste, overuse of technology, physicians fees, hospital costs, and medical malpractice liability fees.

The Health Care Dollar

To better understand the rapidly rising health care costs, it is useful to consider how the health care dollar is spent.

Table 1 compares the components of the health care dollar in 1965 and 1987. Although the order of spending has not changed since 1965, the distribution has shifted. In particular, the share of the health care dollar spent on hospital care has increased significantly as has nursing home care; while other professional services and research, construction and public health has declined.

TABLE 1.—THE HEALTH CARE DOLLAR

	1965	1987
Hospital care	$0.33	$0.39
Other professional services [1]	.27	.21
Physicians services	.20	.20
Research, construction and public health	.14	.12
Nursing home care	.05	.08

[1] Includes dentists, chiropractors, podiatrists, optometrists, and medical products.

Source: Health Care Financing Administration.

Absolute Dollars

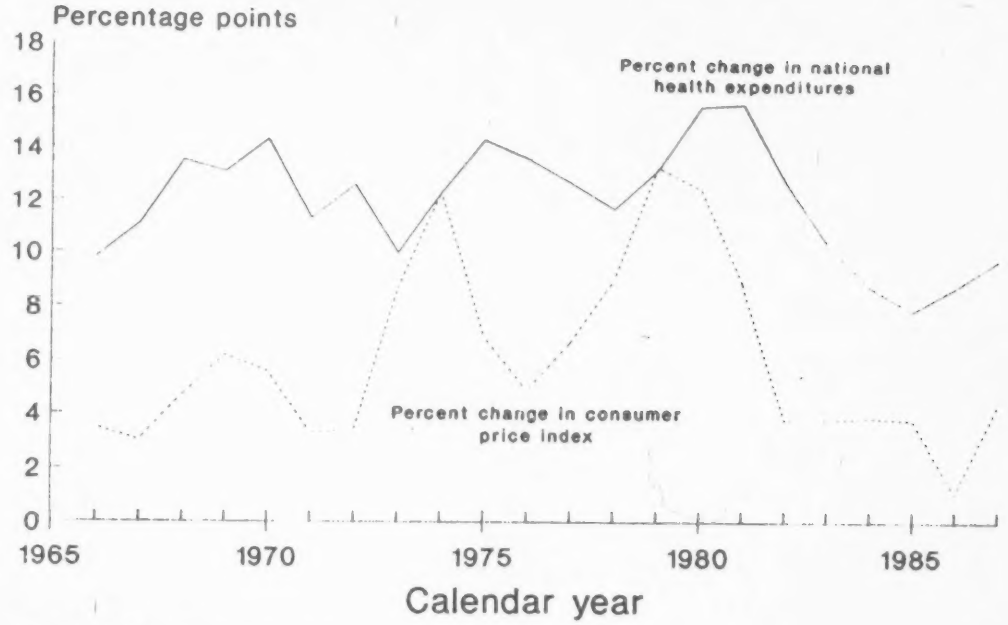
In 1950, the Nation spent $12.7 billion on the health sector; by 1988, national health spending increased to about $540 billion. To facilitate comprehension of these enormous sums, Ms. Karen Davis, of Johns Hopkins School of Hygiene and Public Health, provided graphic descriptions: in 1950, the Nation was spending *a billion dollars every month* on health care; by 1988, it spent *a billion and a half dollars a day.* To further assist in understanding the magnitude of expenditures, Ms. Davis translated these gross amounts into per capita spending. In 1988, $2,136 was spent for each man, woman, and child compared to $80 per person in 1950.

Growth Rates

Health care expenditures in the United States increased by over 1000 percent between 1965 and 1986. As indicated in Figure 1, while growth rates peaked in the 1980 and 1981 when they increased by 15.6 and 15.7, respectively, in 1987 the 9.8 percent increase still exceeded the inflation rate by 5.4 percent. Even after adjusting for inflation, the growth in this sector has been extraordinary for the past two decades. Personal health care spending in the United States rose 172 percent from 1965 to 1986 after adjusting for inflation.

Figure 1

Percent Change in Health Expenditures and Consumer Price Index Calendar years 1965-1987



Source: Health Care Financing Admin. and Economic Report of the President

Components of Change

The health care sector is not monolithic. Therefore, to understand its rapid growth better, it is useful to evaluate the differential growth of its various components. Data submitted to the Subcommittee by Daniel Waldo, an economist with the Health Care Financing Administration, reveals a significant change in growth rate patterns in recent years. As indicated in Figure 2, other professional services, previously the second largest growth component, is currently first and, in conjunction with physician services, has led the growth in health care costs. Growth in nursing home care costs, which for the past two decades was far greater than any other increase, has slowed considerably. Nursing home care cost increases are now increasing only slightly faster than hospital costs—the slowest growth component.

Price Inflation

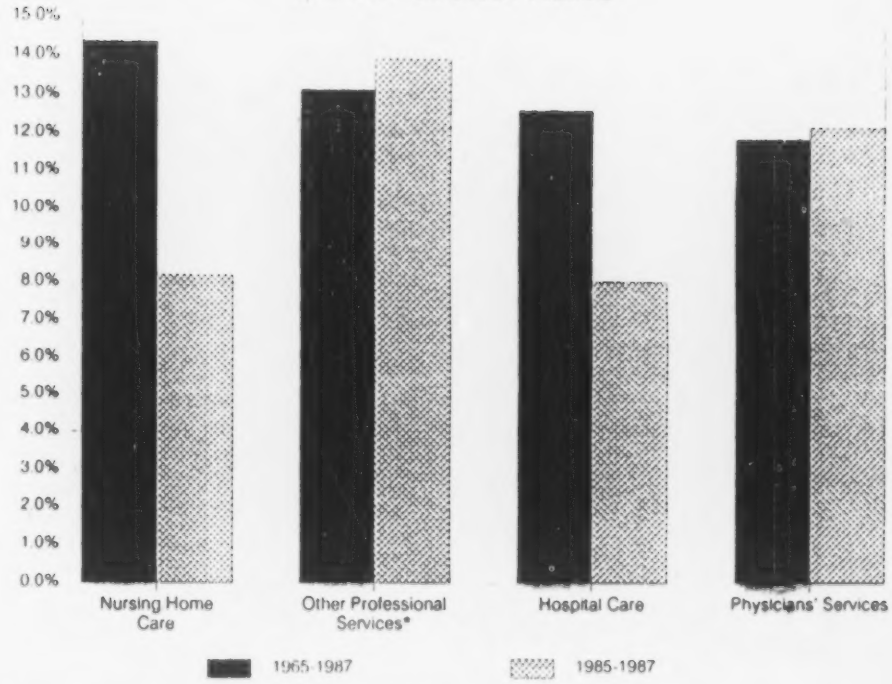
To explain the growth in health care expenditures, Dorothy P. Rice, Professor, Institute of Health and Aging, University of California at San Francisco, suggests that three factors be considered:

1. The rise in medical prices relative to the general price level;
2. Demographics; and
3. Utilization rates; that is, how many people are treated and how many services are performed.

According to Ms. Rice, population increase accounted for only 8 percent of the $368 billion increase in personal health care expenditures between 1965–86; and the combination of utilization increases and quality improvements accounted for 26 percent. The bulk of the growth in health care spending, 66 percent, is attributable to price inflation—rising prices for medical care.

Medical price inflation is so robust that in one year, 1986, it accounted for almost one-fourth of the total increase in health care spending. Moreover, if medical prices had increased at the same rate as the average of all other consumer prices between 1965 to 1987, health expenditures in 1987 would have been reduced by $85 billion. This would have effectively reduced the health care component of the GNP by almost 2 percentage points to 9.1 percent.

Figure 2
Selected Health Care Costs
Annual Growth Rates



* Dentists, Chiropractors, Podiatrists, Optometrists, and Medical Products

SOURCE: Health Care Financing Administration

Gross National Product

Mr. Waldo pointed out that growth in health spending has exceeded that of the GNP . . . with "almost monotonous regularity." Figure 3 illustrates that health spending as a share of the GNP was 4.4 percent in 1950. In 1988, it was 11.5 percent, almost 50 percent more than the average for other members of the Organization for Economic Cooperation and Development [OECD] and more than any other country. Because of the increasing share of our GNP devoted to health care, Ms. Davis advised the Subcommittee, "as more of the Nation's income was going for health care, relatively less was left over for food, housing, and other nonhealth care goods and services."

International Comparison

To get a sense of the magnitude of America's health care costs, it is instructive to consider health care spending in other countries. George J. Schieber, Director, Office of Research, Health Care Financing Administration, advised the Subcommittee that the United States spends, by far, more per person on health care than any other OECD country. In 1985, health spending in OECD countries ranged from $252 per person in Greece to $1,765 in the United States. Mr. Schieber testified:

> Spending in the United States was 38 percent higher than Canada, the second highest country; 49 percent higher than Sweden, the third highest country; 184 percent higher than the United Kingdom, the 17th ranked country; and 600 percent higher than Greece, the last ranked country.

Similarly, as indicated in Table 2, per capita spending and the share of the Gross Domestic Product [GDP] which the United States devotes to health care far exceeds that of other countries. "The United States not only devotes the largest share of its GDP to health," advised Mr. Schieber, "but its share is almost 50 percent higher than the OECD average."

TABLE 2.—HEALTH CARE SHARE OF GDP

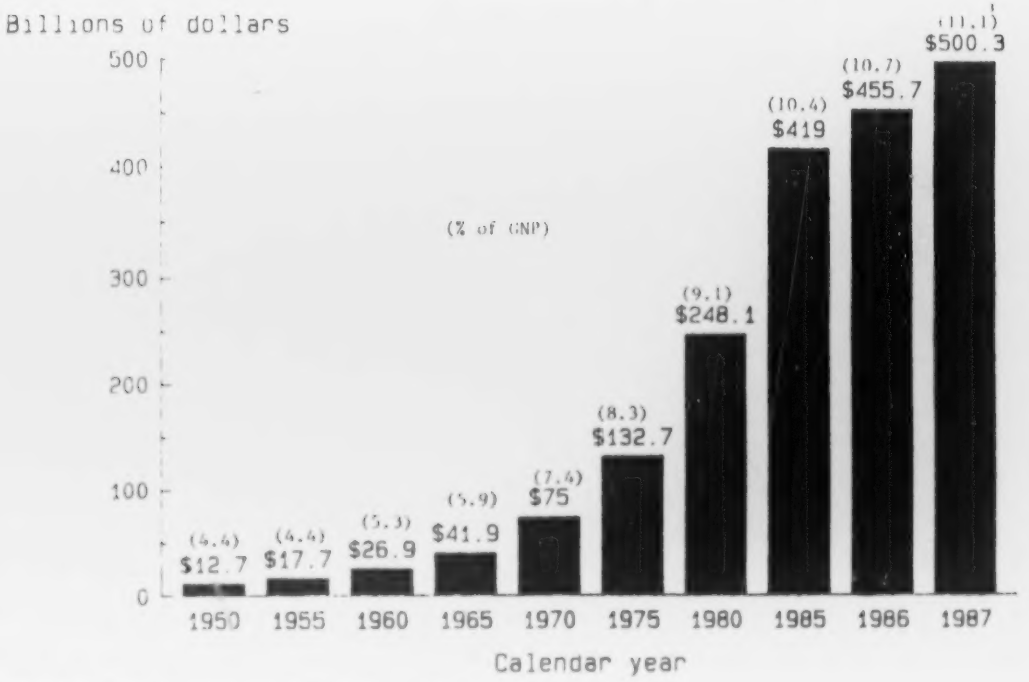
[In percent]

	1960	1975	1980	1985
OECD	4.0	6.9	7.1	7.3
United States	5.2	8.4	9.2	10.7

Source: Testimony of George Schieber.

Figure 3

National health expenditures as a percent of GNP
Selected years, 1950-87



Health Care Financing Administration,
Office of the Actuary;
Data from the Office of National Cost Estimates

Mr. Schieber did caution that, in comparing expenditures, availability and utilization of services differ substantially across countries. Figure 4, therefore, compares the number of inpatient medical care beds and the number of physicians per 1,000 population as well as length of hospital stays and hospital expenditures per day and per admission.

The incongruous situation indicated in Figure 4—extremely high U.S. expenditures and low utilization rates relative to other OECD countries—is the root of the problem with which public policymakers concerned about health care must grapple in the next several years.

Ms. Davis projects that, left unchanged, health care costs will continue to skyrocket and that by the year 2000 the Nation will be spending $970 billion or $3,500 per person in constant 1988 dollars. This would consume over 15 percent of the Nation's GNP.

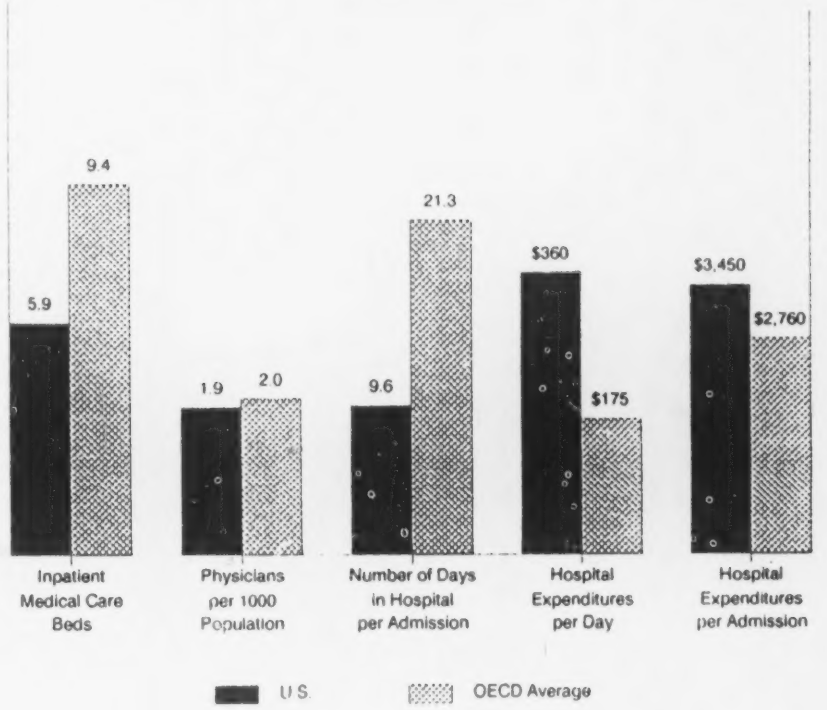
The consequences of continued rising health care costs were outlined by Ms. Rice:

- Private health insurance premiums have recently jumped at unprecedented rates—20 to 30 percent.
- The ranks of the uninsured are growing—estimates range from 31 million to 37 million Americans who have no medical coverage. Of equal concern are the millions whose existing insurance is inadequate.
- Older people are being discharged from hospitals quicker and sicker.
- One-third of the near-poor elderly are reduced to poverty by their out-of-pocket payments for medical care.
- Many States have raised their requirements for Medicaid eligibility and have reduced benefit payments.
- Many acute and chronically ill persons are slipping through the "safety net" as economic pressures on the medical care system mounts.

Perhaps the most serious price that Americans pay for such an expensive system, according to Uwe E. Reinhardt, Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University, is that it has created an American tragedy—it has made us reluctant, as a people "to be our brethrens' keeper in health care if these brethren are sick, poor, and uninsured."

The following sections discuss some of the factors adding to increased health care costs. These include pluralism and dysfunction, overuse of technology, physician fees, hospital costs, and medical malpractice liability insurance.

Figure 4
Health Care: U.S. vs. OECD
1980s



PLURALISM AND DYSFUNCTION

One of the hallmarks of the American health care system is its pluralism; that is, Americans have a wide choice of insurers and health care providers. This, according to Uwe Reinhardt, of Princeton University, is what makes the system so expensive. While it guarantees Americans a great deal of choice, it is inherently costly because it requires tremendous administrative overhead involving the processing of claims for payment or reimbursement in the wake of illness.

Mr. Reinhardt describes the system as follows:

> . . . we, as Americans, insist that we should have literally hundreds of companies from which we can choose. We spend hours choosing. They spend hours printing paper advertising to us, running around marketing it. If we then insure, we spend hours sending in claims. They spend hours fighting all of the claims.

Mr. Reinhardt charges that "for better or for worse, the American health system is *the* most bureaucratic health system anywhere in the industrialized Western democracies." To cope with the paperwork created by the bureaucratic nature of our system, American physicians employ at least one full-time office worker to handle the paper flow involved in insurance coverage.

Mr. Reinhardt estimates that the added paperwork and duplication of capacity created by our pluralistic system may add as much as $20 surcharge to the cost of health care for each $100 spent for health services. This 20 percent surcharge, according to Mr. Reinhardt, serves one purpose—the preservation of a pluralistic system including bureaucracy, paper pushing, and "the awesome army of nonhealth workers who nourish themselves fiscally on the process of health care." Mr. Reinhardt elaborated:

> Whatever the virtues of pluralistic health care may be, Americans should realize that these virtues are purchased at a very stiff price. One can only hope that the virtues justify this price. I am not sure it does.

An additional price we pay for pluralism is, Dr. Heagarty of Harlem Hospital testified, that "we have invented systems that nobody can understand." Thus, our health care system has been identified by Seymour Perry of Georgetown University Medical Center, as a "dis-system as in dysfunction." Dr. Perry describes this "dis-system" as:

> . . . a conglomeration of health care delivery mechanisms ranging from private solo-practice physicians to HMOs to corporate hospital giants, where the use of procedures, however inappropriate, is rewarded while the traditional role of physicians, which we fondly remember as general

> practitioners with wonderful bedside manners, is penalized. Coverage for health care ranges from expensive total coverage by private third party payers through Medicare and Medicaid with the deficiencies in those two programs, to the absence of coverage for approximately 37 million people.

Dr. Perry asks, "With a mishmash like this, why do we seem so surprised that health care costs continue to rise and that health care delivery in this country is so inefficient? He concludes that while pluralism in some instances is good it might not be serving us well in our health care system "in which inefficiency, waste, and overuse and inappropriate use of medical technology are fostered."

THE APPROPRIATE USE OF TECHNOLOGY

George Schieber of the Health Care Financing Administration, asked, "Are Americans getting better quality [health] care, more amenities, and/or are we simply more wasteful?" Although it is difficult to document that care in the United States exceeds that of many other OECD countries which spend less on health care, there are countless examples of waste. In terms of quality, the United States lags our allies on several important measures, most notably infant mortality and life expectancy.

Infant mortality: As indicated in Table 3, of the 22 OECD countries, the United States ranks No. 1 in health care spending and 20th with respect to infant mortality, with 10.6 deaths per 1,000 births. Only Greece and Portugal fare worse than the United States in this regard. Countries that spend far less than the United States, according to Mr. Schieber, such as Japan and Finland, perform much better with respect to infant mortality. Their rates are 5.5 and 6.3 deaths per 1,000 live births, respectively.

TABLE 3.—INFANT MORTALITY RATE—1986

[Deaths per 1,000 births]

	1986	Rank
Country:		
Iceland	5.1	1
Japan	5.5	2
Sweden	5.9	3
Finland	6.3	4
Netherlands	6.4	5
Switzerland	6.8	6
Canada	8.0	7
France	8.0	7
Denmark	8.4	9
Norway	8.5	10
Germany	8.6	11
Ireland	8.7	12
Spain	9.4	13
United Kingdom	9.5	14
Belgium	9.7	15
Australia	9.9	16
Italy	10.1	17
New Zealand	10.2	18
Austria	10.3	19
United States	10.6	20
Greece	12.2	21
Portugal	15.8	22
Average	8.8	

Source: Testimony of George Schieber.

Life expectancy: Life expectancy in the United States is 75 years. The United States ranks eighth behind Japan, Spain, Canada, The Netherlands, Italy, Australia, and West Germany.

With respect to waste and inefficiency in the U.S. health care system, examples are plentiful.

According to Joseph Califano, the former Secretary of the Department of Health, Education and Welfare, for every $4 spent on health care in America, $1 is wasted. In 1988, this amounted to over $125 billion.

While there is wide agreement that something needs to be done to curb waste and excessive costs, there is little agreement about where the waste is and what needs to be cut. Witnesses agreed, however, that excessive use of tests and procedures is contributing significantly to the exorbitant cost of health care in America.

Technology

"Modern health care," the Subcommittee was reminded by Dr. Perry of Georgetown University Medical Center, "is expensive under the best of circumstances. Health care delivery 50 years ago was far less expensive because there was little in the way of technology that the hospital or doctor could 'deliver'."

Medical technology was defined for the Subcommittee by Clyde Behney, Health Program Manager, Office of Technology Assessment, U.S. Congress, as "the drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided."

Undoubtedly, the strides in health care made possible through medical technology, are nothing short of miraculous. Mr. Waldo testified that "lens implantation, coronary bypass, and other procedures allow treatment of previously untreatable conditions. CT, PET scanning, and magnetic resonance imaging (MRI) provide diagnostic information that previously could not be obtained, or that could be obtained only with peril."

The miracles aside, technology is very expensive. Mr. Behney informed the Subcommittee that new technologies, new applications of existing technologies, or increased use of existing technologies in traditional ways are responsible for as much as 25 percent or more of the dramatic increases in health care costs over the past two decades.

Overutilization

Beyond the costs inherent in technological advances, however, the overutilization of technology has profoundly exacerbated the health care cost problem.

According to Morris Abram, an attorney, and former Chairman of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "20 or 30 percent of all things done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary." Dr. Perry asserts that 20 percent of diagnostic tests may be unnecessary. In 1987, that accounted for $27 billion for laboratory tests alone and more than $100 billion for all types of tests.

Not only tests, but high-technology procedures are frequently being overutilized. Mr. Behney urged, that notwithstanding its positive effects, it is imperative to question "what have the benefits been in relation to risks and to economic and social costs, and in relation to alternative ways of accomplishing the same goals." In other words, "how closely has use of medical technology approached 'appropriate use'? The inappropriate use of technology is," according to Dr. Perry, "a serious factor in raising the cost of health care." He describes inappropriate use as instances where the technology is used in ignorance, for a marginal benefit to the patient, in the absence of evidence of its value or in spite of the fact that conclusive studies have not been done.

Not only is the excessive use of procedures a concern, but the lack of uniformity with which procedures are used raises serious questions about equity and quality of care. For instance, Joseph Califano pointed out that a resident of New Haven, Connecticut, is twice as likely to have coronary bypass surgery as a Bostonian but only half as likely to receive a cartoid endarterectomy. Bostonians are much more likely to have their hip and knees replaced while New Haven residents had far more hysterectomies and back operations. These different treatments for similar populations appear to bear no relation to whether the patient gets well.

Patients' Attitudes

The excessive use of tests and procedures is, in part, perpetuated by patients' attitudes. Mr. Califano explained to the Subcommittee that "patients have come to judge physicians by how much doctors do to them—how spectacular their diagnostic and treatment procedures are, how high-tech their offices and hospitals are." Changing patient attitudes, according to Mr. Califano, is a necessary step in the process of reducing unnecessary procedures and ultimately reducting health care costs.

Changing patient and physician attitudes about technology is extremely difficult because, according to Stanley J. Reiser, M.D., Professor at the University of Texas Health Science Center at Houston, technology is more than a process:

> It is a symbol of status, a measure of power, an agent of values. . . . Its use is influenced not merely by its physical effects of illness, but on our vision of who we are, and mores of the social system in which it is embedded.

Dr. Reiser explained that beyond the illness-reducing capability of technology, the mere availability and use of these tools serves a purpose to patients, health care providers as well as to the way society perceives itself. Technology offers:

- Patients the miracle righting the wrongs of heredity and life;
- Health providers the power to alter the course of pathological forces as well as status from having the knowledge to do so; and
- Society the affirmation that ours is an advanced civilization able to develop life-saving and pain-reducing measures for those who need them.

These social and psychological factors play a large role in perpetuating the widespread use of some procedures. For instance:

- 900,000 cesareans were performed in the United States in 1986. It is estimated that at least half of them were unnecessary. The cost of these excess operations was $728 million dollars;
- 250,000 Americans have coronary bypass operations each year, making Americans four times more likely to have coronary bypass surgery then Western Europeans. Yet, 60 percent and perhaps 80 percent of the Americans who undergo these procedures gain no increase in life span beyond what they would have achieved through medical management of their conditions. At $25,000 per bypass that is a cost of over $5 billion for unnecessary procedures; and
- 120,000 pacemaker implants are performed each year in America at a cost of $1.5 billion. At least half are thought to be unnecessary or of questionable value.

Dr. Perry warned that "the vast majority of medical procedures now in use have never been subjected to careful evaluation." In fact, it is estimated that 80 percent to 90 percent of all medical procedures have not been adequately assessed. As a result, many new technologies have moved from research into the practice of medicine before their safety and effectiveness have been clearly defined. At the same time, Dr. Perry continued, many old, obsolete, and ineffective technologies continue to be used for years, even after new, more effective technologies have been introduced.

Dr. Perry attributes this "technological imperative" to four factors:

1. Patient demand;
2. Technological style of practice reinforced by third-party payment systems;
3. Training of young physicians in technologically intense medical centers; and
4. Hospital competition to attract expert staff and patients by acquiring the most sophisticated and newest technologies.

Ethical Questions

In addition to contributing to increased health expenditures, technologies are raising major ethical and moral issues of access and equity, particularly in the current setting of financial constraints. Dr. Perry pointed out:

> The poor and disadvantaged may not have access to potentially beneficial and life saving technologies no matter what definition is used for "minimal level of care." There are the complicated and controversial questions about maintaining life in the dying at any age ranging from infants with severe neurological defects to the terminally ill elderly.

Dr. Perry also cited the enormous cost and controversy of intensive neonatal care on premature babies. Saving the life of a one-pound baby costs hundreds of thousands of dollars up front and

perhaps millions of dollars down the road to care for mentally and/or physically handicapped babies throughout their lives.

The task before us, Dr. Perry concludes, is determine "how to integrate in a rational and equitable manner expensive, beneficial medical technologies in a climate where there is so much concern over cost containment."

PHYSICIANS' FEES

Physician fees and methods of payments are an integral factor in the health care cost equation. ". . . physicians—through their dominant role in hospital and nursing home admissions and lengths (of stay), tests, procedures, treatments, and prescriptions—influence 60 to 80 percent of total health care spending," according to Lynn Etheredge of the Consolidated Consulting Group. In fact, Mr. Etheredge informed the Subcommittee that physicians' revenues in 1986 were $92 billion, a 20-percent share of total national spending on personal care services. In the 1980–86 period, national spending on physicians grew 11.9 percent annually, compared to 10.7 percent for all personal health care expenditures.

It is not merely the increase in physician costs which must be considered. The method of payment systems prevalent in the United States, Mr. Etheredge charges, "contains biases . . . towards institutional care, excessive tests, and unnecessary procedures (which) may lead to higher health care inflation than is directly measured by rising spending for physicians' services alone."

Payments to physicians are generally made in one of four ways:

1. Fee-for-service—a specific charge for each service;
2. Salary—compensation based on unit of time such as a fraction of an hour;
3. Capitation—a fixed annual fee per patient such as a fixed payment per insured person to a Health Maintenance Organization (HMO); and
4. Fee-for-episode—a fixed payment for a specific illness such as treatment of an appendectomy.

Fee-for-Service

Fee-for-service is the approach most frequently used for paying physicians' services in most countries. In most industrialized countries that use fee-for-service, the amount of the fee is set by the payers; that is, by the insurance companies or governments or negotiated between providers of health care services and payers. In some countries there is a universal payer. A fee schedule in these countries specifies how much will be paid for each service. The advantage of fee-for-service is that it is a flexible, and if not abused, fair system that permits payment of physicians based on the number of services which they perform in their work.

However, the way fee-for-service has developed in the United States has been unique and has given rise to a special set of problems. A fee schedule existed in the United States prior to the enactment of Medicare. Indemnity insurance companies had established fee schedules which indicated how much they would pay health care providers for a specific service. The schedule provided a

guideline which was not determined solely by the health care providers.

At the same time, Blue Shield Plans were using a reimbursement method based on "usual, customary, and reasonable (UCR) charges. Under UCR, physicians are paid the amount they bill for a service providing it does not exceed their "usual" charge for the service for that patient or the "customary" charges for all patients. Medicare's current system, the "customary, prevailing, and reasonable" (CPR) method, was intended to keep Medicare's payment rates in line with other payers' rates.

In 1965, when Congress was considering Medicare legislation, a national government-set fee schedule was extremely controversial. To minimize the controversy, Medicare adopted the UCR approach then being used by Blue Shield Plans. However, it was thought that the existing fee schedules of private insurance companies would serve as a guide to what was reasonable and customary.

The existing fee schedule, however, was abandoned by private insurers in favor of UCR/CPR soon after Medicare's enactment. The result was a situation whereby the private sector eliminated the guidelines that it was hoped Medicare would use as a basis for determining reasonable payments. Instead of Medicare relying on the fee-for-service schedule established by private insurers, as a guideline, the private insurers have opted to use the Medicare approach. The result is that physicians are, themselves, determining their fees without any guidelines. And, without the guidelines, all patients have been paying an ever-spiraling price for medical care.

In an effort to gain control of the runaway increases in physician services, the Physician Payment Review Commission has recommended that Medicare, starting in 1990, replace CPR with a Medicare Fee Schedule. So if and when the fee is implemented, the Nation will, finally, be on the way to where it should have been 25 years ago in terms of setting reimbursement costs for physician fees.

Currently, in the United States, fees are primarily set by physicians. Although 72 percent of physicians' income is paid for by insurance, according to Mr. Etheredge, the insurers' "largely pay whatever the physician charges and have increased those payments each year to keep pace with physicians' fees." Because of these factors, the American system is characterized by runaway health cost inflation. Mr. Etheredge concludes that:

> Physicians' fees for many services (particularly heavily insured services) are now out-of-line both in comparison with the physicians' time and other costs of providing these services and in comparison with other services such as office-based primary care visits.

The fee-for-service payment method is a flexible system that can accommodate a high degree of complexity and rapid change in medical care practice. However, the major disadvantage, as Mr. Etheredge testified, is that "it tends to produce a runaway in physician volume increases because that's what it pays for. . . . The more patients seen, the more services billed, and the more highly priced these services, the greater a physician's income." As a result, in the last 15 years, physicians' real incomes have remained

constant (at an average of $120,000 per year) despite an increase of 60 percent in the supply of physicians.

Further, there is no incentive provided for the physician to spend time talking to and reassuring patients, answering questions or discussing good health habits. As Paul B. Ginsburg, Executive Director, Physician Payment Review Commission, testified, "today, a physician can make several times more per hour doing endoscopies then evaluating patient problems and developing treatment programs." The system pays for, and, thus, encourages procedures. Accordingly, there has been a dramatic proliferation in the use of procedures and technology. In the last two years, when Medicare instituted the Diagnostic Related Group (DRG) system and froze physicians' fees, the volume of laboratory services increased 182 percent while Medicare enrollees rose only 4 percent! Further, Mr. Ginsburg charged that "excessive payments for procedural services such as pacemaker insertion and cataract surgery may lead to overuse of these services, increasing outlays without comparable improvements in care."

The system, through income differentials, has also encouraged some physicians to specialize in certain medical areas. As Mr. Ginsburg pointed out, "the primary care physician, dealing with an office visit is only selling his or her time. . . ." Thus, in 1986 the average income of a general practitioner was $80,300 compared with $168,800 for a radiologist. Although part of the differential represents differences in training, stress, and work effort, it was suggested by several witnesses that high "profits" in certain specialties tend to encourage specialization.

Finally, the fee-for-service system in the United States today is incredibly complex to the point of being almost incomprehensible to many patients and physicians. Medicare CPR payments are calculated separately for each of the Nation's 325,000 office-based physicians for over 6,000 different procedures. When different specialty and other circumstances are considered, a Medicare carrier can have several times this number of fee categories. In fact, Mr. Etheredge advised the Subcommittee that Medicare now must review and pay bills for over one-half billion Part B (physician) services annually.

It has been suggested that reform of the current fee-for-service system in the United States in favor of the more traditional approach of physicians and payers negotiating fees would eliminate many of the problems inherent in our system. In particular, the Canadian model is held up for comparison.

Canadian Experience

Canada is a very similar society with similar medical care industries; that is, according to Robert G. Evans, Department of Economics, University of British Columbia, effectively identical technology and training programs and predominantly fee-for-service payment procedures.

In fact, Mr. Evans explained to the Subcommittee, prior to 1971, the United States and Canada had very similar funding systems based on a mix of self-payment and private insurance. In both countries it was clear that there was emerging a growing propor-

tion of the population who could not pay for needed care or afford private insurance. The United States, Mr. Evans continued, responded to the problem with specific, categorical programs for disadvantaged groups. Canada, on the other hand, chose instead to provide universal coverage to the entire population through a public system. In 1961, every province had a program in place for reimbursing all "medically necessary" hospital services. The system of public coverage was extended to cover physician services in the 1960's. Physicians were reimbursed by a fee according to a particular schedule negotiated periodically between the provincial medical association and the provincial insurance programs. By 1971, every province in Canada provided coverage for all of its residents against all "medically necessary" costs of hospital and medical care.

Mr. Evans summarized the differences between the American and Canadian approaches to health care reimbursement:

1. Sole-source versus multiple-source funding: The Canadian provinces are the only reimburser for hospital and medical care as opposed to the American system where funds flow from many sources and through many channels. No one agency has both fiscal responsibility for and administrative authority over total outlays on health care.

2. Universal versus categorical funding: The Canadian programs cover all residents in each province or territory. In the United States, insurance coverage depends on past or present employment, age, income level, welfare status, or residence.

3. General tax revenue versus mixed-source funding: The burden for paying for health care in Canada is distributed in proportion to that of the overall tax system. In the United States part of the burden is distributed in this way, but part (about one-third) falls on those who experience illness, as they pay for their own care, and part flows through private insurance premiums.

4. First dollar versus partial coverage: The Canadian plan pays the full cost of care, directly to the provider, so that the patient is not financially involved. American public programs similarly deal with some providers; with others they reimburse the patient and the patient is responsible for the provider's bill. In either case, the patient, through deductibles and copayments, may be responsible for a significant share of the bill. Private insurers offer a similar range of options—from the HMO where a capitated fee provides for total patient care to partial reimbursement of the patient for the provider's bill.

The differences in the results between the Canadian and American experiences are vast, indeed. As previously discussed, in the United States, medical expenditures constitute over 11 percent of GNP; in Canada it is 8.6 percent. Further, while some 37 million Americans lack any health insurance and millions more have inadequate coverage, all Canadians have virtually complete coverage with no financial liability for care. Finally, in the United States, dissatisfaction is common among users of and payers for the system, whereas in Canada, patients and taxpayers are overwhelmingly satisfied. On the other hand, Mr. Evans points out, in the Canadian system, particularly in its relationship with physicians,

there is "open and apparent conflict . . . perhaps not unrelated to the fact that in Canada cost control has been successful."

Salary

Salary, or payment based on the time spent in providing professional services, is the second most common method for paying physicians in the United States. Salaries were the major payment method for about 165,000 physicians, about one-third of the Nation's 490,000 active physicians in 1985, Mr. Etheredge reported. This included physicians in hospital-based practice, private physicians in teaching and administration, and federally employed physicians.

A major advantage of the salary-based system is its simplicity compared to fee-for-service billings. A second advantage is that it removes the fee-for-service system's incentives to multiply the volume of services. A physician is paid comparably for providing his or her best professional care, whether counseling, diagnostic testing, or procedures without being biased by the financial incentives inherent in the payment system.

The drawbacks are that salary-based payment lacks the service incentives and productivity rewards of fee-for-service. If a physician is paid the same amount regardless of the number of services provided, he or she may provide too few services.

Capitation

Capitation is a payment method wherein a physician, physician group, or other organization is paid a predetermined amount for services to a defined population. This approach controls total expenditures directly—including volume control.

Capitation methods have come to be associated with Health Maintenance Organizations which now enroll about 13 percent of the population. A disadvantage of capitation is that there is incentive for underservice since a provider keeps more profit the fewer services he or she provides. Also, calculating capitation payments involves overcoming the difficult problems of determining fairness, incentives, and risks on all sides. Mr. Etheredge concludes that capitation payments have a potential for being an effective cost control method. However, the potential may not be realized because in a sense the United States has had a capitation-based insurance system for years (insurers received a preset premium per patient within which they had to manage expenses) but this payment method did not reduce costs because a commitment to cost restraints and a management infrastructure were missing, according to Mr. Etheredge.

Fee-for-Episode

Fee-for-episode is a fixed fee for a package of services. This method, according to Mr. Etheredge, is now used in instances where normal service packages can be reasonably well defined, e.g., cataract operations, obstetrical care.

Simplicity in billing and improved ability for the purchaser to "comparison shop" on the basis of price for a full service package

are fee-for-episode's biggest assets. Mr. Etheredge maintains that cost containment through this approach could result if episodal or global fees were established for conditions and/or treatments that were experiencing an unwarranted expansion in volume of services. In these situations, the global fee could help to restrain expenditure growth, according to Mr. Etheredge. While fee-for-episode works well when normal service packages can be reasonably well defined, i.e., cataract surgery, obstetrical care, it is not well suited to situations which involve less standard procedures.

HOSPITAL COSTS

Hospital costs represent nearly 40 percent of the health care dollar and 4 percent of the GNP. Despite major initiatives to contain hospital costs, hospital expenditures continue to escalate rapidly, increasing at an average annual rate of 10.2 percent from 1980–86—over twice as fast as the inflation rate.

Among the factors explaining rising hospital costs cited by witnesses are:

1. The fee-for-service reimbursement system;
2. The aging of the population;
3. New diseases;
4. The nursing shortage;
5. New technologies; and
6. Surplus hospital beds.

The rate of increase in costs is accompanied by concerns that the costs of providing certain hospital services may exceed the benefits of providing them. Particularly disturbing is the possibility, articulated by Gerard F. Anderson, Director, The Center for Hospital Finance and Management, Johns Hopkins Medical Institutions, that the level of spending may be related more to peculiarities of the hospital finance and delivery system than to the expected gains in health outcomes. That would mean that the high and rapidly rising costs are inherent in our health care system and, barring a major overhaul, little can be done on an incremental basis to reduce costs.

Payments to hospitals made by private insurers, like most payments to physicians, are generally based on a fee-for-service. If additional services are performed, additional charges are incurred by the patient. As in the case of physicians, there is an incentive for hospitals to overuse services as each service is reimbursed in an amount determined by the hospital with little or no input from the patient or third party payers.

Efforts To Reduce Costs

Numerous efforts to reduce hospital costs have been made in recent years. Much of the cost containment effort has focused on three goals:

1. Increasing competition, i.e., preferred provider organizations (PPOs), and comparative reports on resource utilization of providers compiled by insurance companies;
2. Reducing inpatient days, i.e., Health Maintenance Organizations (HMOs) and the Prospective Payment System (PPS) in the case of Medicare and preadmission certification for hospital admissions and second opinions for surgery required by some insurers; and

3. Regulating prices, i.e., the Prospective Payment System (PPS).

Mr. Anderson argues that because many of the requirements for a competitive market do not exist, attempts to increase competition do not seem to work in the hospital setting. For example, widespread health insurance insulates consumers from the true price of hospital care; it is difficult for many hospitals to enter or exit from the market; and many communities contain only one hospital.

There is, however, an opportunity for some degree of price competition, according to Mr. Anderson. Thus, the Preferred Provider Organizations have grown in recent years. Under this arrangement, an organization brings together low-cost or efficient hospitals in an effort to capture a greater portion of market share. For instance, hospitals may reduce the price of services so the PPO may offer price discounts to consumers who choose to use the more efficient, participating providers. To date, Mr. Anderson concluded, little is known about the success of PPOs in constraining hospital cost increases.

HMOs were offered as examples of health care alternatives which reduce hospital costs. Daniel Dragalin, M.D., Vice President, Group Medical Services, The Prudential Insurance Company of America, Inc., advised the Subcommittee that HMOs are founded on the principle that the provider has an incentive to provide appropriate care in a cost-effective way. According to Dr. Dragalin, HMOs have had a major impact in slowing the growth in health care costs. HMOs average utilization of inpatient days per 1,000 enrollees is 427 and an average length of hospital stay is 4.7 days compared to a national average of 920 days per 1,000 population and an average length of stay of 6.5 days. In addition, HMO members experience up to 40 percent fewer admissions and save up to 28 percent on health care costs, compared to those in a fee-for-service system. These cost savings, Dr. Dragalin emphasized, were not reflected in lower levels of health status. HMOs, however, while serving increasingly large constituencies, are not the provider of choice for most Americans who still seem to prefer to select their own physicians. Currently, only about 13 percent of the population belong to HMOs.

A third approach to hospitasl cost containment is a quasi-regulatory administered price system. In this case, third party payers such as Medicare, set the price they are willing to pay for hospital care. As with physician payments, because Medicare represents such a large part of total hospital costs—27 percent in 1987—and Medicare payment practices tend to be adopted by the rest of the health care system, it was anticipated at the outset that Medicare's Prospective Payment System (PPS) would lead the way to dampening hospital cost increases.

Under PPS, Medicare sets the prices for over 470 diagnosis related groups (DRGs) and then modifies the payment depending on the price of input costs in the local area, the level of teaching, care for the poor, and certain other factors. Unfortunately, this approach is not as effective as it might have been because, as Mr. Anderson testified, it is becoming very complex for the system to adjust for all the differences among hospitals.

Donald Young, M.D., Executive Director, Prospective Payment Assessment Commission, informed the Subcommittee that PPS has had "mixed effects on health care in America." Although the rate of increase in Medicare inpatient hospital expenditures has slowed substantially, Dr. Young bemoaned the fact that total Medicare expenditures have continued to increase at rates significantly above the rates of inflation. He concluded that declining inpatient hospital admissions and length of stay have been offset by substantial growth in expenditures in outpatient settings and a shift in payments from Part A (hospitals) to Part B (physicians).

Thus, Mr. Anderson concluded, "despite the multitude of cost containment initiatives adopted in the past several years, most of the evidence suggests that current initiatives have been unsuccessful." Not only have hospital costs continued to rise faster than the rest of the economy, but the hospital industry, according to Mr. Anderson, "has done little to promote efficiency and in fact, has actually taken actions which will increase overall costs."

As evidence, he cites the following:

1. Between 1983 and 1987 the number of inpatient days declined by 17 percent. During this period, the number of full-time equivalent personnel was reduced by only 3 percent.

2. At the end of 1987, less than 63 percent of hospital beds were occupied. In 1986, 41 percent of all hospitals were operating at less than 50 percent occupancy and 57 percent were operating at less than 60 percent occupancy. Yet, hospitals were engaging in significant capital spending about half of which was for new construction.

3. Overall productivity in the hospital industry has declined in the 1980's as both the number of personnel per patient and the quantity of capital per patient have increased dramatically.

Witnesses offered various explanations for these trends. Jack Owen, Executive Vice President, American Hospital Association, suggested that voluntary hospitals spent about $4.2 billion on unsponsored care in 1987. He estimated that "To pay for care provided to the medically indigent, private payers must on average pay a hidden tax of 10.6 percent. . . ." Mr. Owen also argued that hospital costs are rising because since 1983 hospitals are admitting more severely ill Medicare patients while less severely ill patients are treated in outpatient settings. Further, Dr. Young makes the case that hospital cost reductions are expected to lag admission declines because hospitals are not able quickly to make staff cutbacks and other changes to reduce costs. In addition, Dr. Young testified that hospitals may not have continued pressure on the medical staff to eliminate using services of questionable value.

This, Mr. Anderson advised the Subcommittee, is the real culprit behind increased hospital costs. "The American public wants all of the services the hospital industry offers and is willing to tolerate the concomitant inefficiencies," according to Mr. Anderson. He continued:

It may be our "revealed preference" as a nation that we want to spend a high proportion of our wealth on hospital services. Increasingly I am convinced that we know how to control hospital costs but are unwilling to do so because of the sacrifices involved.

MEDICAL MALPRACTICE ADJUDICATION SYSTEM

> There can be little doubt . . . that the current system is a disaster. It is a cumbersome, expensive, and inefficient method of determining and paying compensation. It is harmful to all who participate in it, and to society at large.

This description of the current medical malpractice adjudication system was provided by John Hoff, Legal Counsel to the National Council of Community Hospitals.

In recent years, an explosion in the number and cost of medical malpractice claims has been a source of increasing concern to patients, policymakers, the insurance industry, and the medical profession itself. Witnesses painted the following pictures of the current medical malpractice crisis:

- In four years, from 1981 to 1985, the number of claims filed against physicians tripled from 3.2 per 100 physicians to 10.1 per 100 physicians.
- Malpractice premiums have increased from $2.5 billion in 1983 to $4.7 billion in 1985.
- The practice of defensive medicine, by which health care providers seek to protect themselves against malpractice lawsuits, adds an estimated $10.6 billion to annual medical costs.
- One out of eight obstetricians/gynecologists have stopped delivering babies because of the threat of malpractice suits.

Three sectors comprise the current medical malpractice system—the legal system, the insurance industry, and the medical profession itself. The general public's understanding and expectations of this system also play an important role. The shortcomings of the legal system and proposals for resolving the medical liability crisis are examined below.

Witnesses testified that, ideally, the system for adjudicating medical malpractice disputes should provide prompt and fair compensation to all patients suffering injury as a result of negligent or inappropriate care. The system should be open to all victims seeking redress and should not exclude anyone because the process is too costly or inconvenient. It should resolve disputes quickly and yield consistent results for similar cases: patients suffering similar injuries should receive equal compensation. And it should deter negligent or inappropriate medical practice while providing incentives for improving the quality of medical care.

Yet, on all of these points, the current system falls short. Witnesses widely agreed that the current system of settling medical malpractice claims through the courts:

- Is costly in both time and money;
- Yields inconsistent and sometimes capricious results;
- Fails to compensate many victims; and

- Does not provide adequate disincentives to poor medical practice.

Impact on Health Care

Witnesses testified that the rising incidence and costs of malpractice claims have had significant adverse impacts on medical care with respect to cost, access, and quality.

Cost of Care

Medical malpractice liability insurance premiums have skyrocketed in recent years. Average premiums paid by self-employed physicians for professional liability more than doubled, rising from $5,800 in 1982 to $12,000 in 1986. According to Roger J. Bulger, President of the American Association of Academic Health Centers, and Victoria P. Rostow, Staff Director of the Institute of Medicine, National Academy of Sciences, the average obstetrician-gynecologist paid $30,500 in 1986 for insurance—an increase of 47 percent since 1984. By 1987, premiums had risen another 21 percent to almost $37,000. Obstetricians in major urban areas paid much more than these national averages. At the end of 1987, medical malpractice insurance for obstetricians with coverage providing $1 million per plaintiff and $3 million per occurrence—the standard amount—exceeded $65,000 a year in Anchorage, Alaska; Dade and Broward Counties in Florida; Baltimore City and Baltimore County, Maryland; Nassau and Suffolk Counties in New York and in the greater metropolitan area of New York City. In addition:

- On an inpatient-day basis, average malpractice insurance costs increased nearly 85 percent from 1983 to 1985 at a time when total hospital expenses increased only 12 percent.
- Adjusting for inflation, 16.4 percent of the average increase in the cost of physician services can be attributed to increased liability premiums based on data from 1983 to 1985.
- Defensive medicine—medical care that is provided primarily to protect against future liability claims for less than certain outcomes—adds an estimated $10 billion to annual health-care costs. These include costs for additional laboratory tests, x rays and outside consultations done for the primary purpose of establishing a record that will be defensible in court.

Access to Care

According to Carter G. Phillips, an attorney and legal consultant to the American Medical Association (AMA)/Speciality Society Medical Liability Project, "one of the most disturbing consequences of the current liability crisis is the decreasing availability of medical care." This is because, as John Hoff advised the Subcommittee, "The fear of malpractice and the cost of increased malpractice insurance premiums forces physicians to abandon high-risk areas of practice." The problem is most serious, but by no means confined to the practice of obstetrics and gynecology. The result has been a dramatic decrease in the availability of obstetrical care in many regions of the country, particularly nonurban areas. For example, Mr. Phillips testified, 44 percent of the counties in Georgia, 42 per-

cent of the counties in Alabama, and 30 percent of the counties in Colorado no longer have any physician (obstetrician or family practitioner) providing obstetrical services. Further, even in areas where obstetrical services are still available, many physicians are restricting the percentage of their practice that is devoted to high-risk pregnancies. The number who have restricted their practices has grown from 18 percent in 1983 to 27 percent in 1987.

Access problems, however, are not confined to these specialities. The experience in Florida, as related by Mr. Phillips, underscores the need for change. Faced with insurance premiums of more than $100,000 a year, medical specialists in Miami began avoiding potentially perilous treatment procedures such as neurosurgery, and emergency rooms refused to admit some patients requiring high-risk procedures such as certain orthopedic techniques.

Not surprisingly, the patients most likely to suffer are the poor, especially poor women in need of obstetrical care, testified Dr. Bulger and Ms. Rostow. They indicated that providers are limiting their participation in Medicaid and maternal and child health programs, avoiding "high-risk" patients who very often are disadvantaged women, and declining to provide services at community health centers. In addition, the increased cost and lack of availability of malpractice coverage for nurse midwives is impairing their ability to provide care, the recipients of which tend to be indigent, minority, and Medicaid-dependent women.

Quality of Care

Witness argued that by promoting the practice of defensive medicine the current medical malpractice system has detracted from the quality of patient care by damaging the physician-patient relationship.

Several witnesses testified that defensive medicine is widespread and increasing. An AMA survey found that 70 percent of responding physicians said that they engaged in defensive medicine, while 42 percent said they had increased their defensive medical practices above past levels.

Noting the strains that it has placed on the physician-patient relationship, Laurence Tancredi, M.D., Director of the Health Law Program at the University of Texas Health Science Center, observed that the current adversary system ". . . discourages the physician from revealing to the patient his doubts and full truth about the outcomes of his management because such disclosures may trigger a malpractice suit." This deterioration clearly reduces the patient's role in his own care and hurts his ability to make fully informed health-care choices.

Mr. Phillips discussed the significant human toll created by the deterioration of the trusting relationship between physician and patient. He concluded that in an era in which over 70 percent of obstetricians/gynecologists have been sued at least once in their careers and 36 percent of all physicians have been sued, it is not surprising that physicians would feel that their relationships with patients have become more adversarial.

OPTIONS FOR CHANGE

National Health Insurance

Throughout the course of the nine days of hearings, the Subcommittee received dozens of suggestions aimed at reducing health care costs and otherwise improving health care delivery in the United States. The calls for a national system of health insurance were, perhaps, the most far reaching but also the most pervasive suggestion.

Dorothy Rice echoed the sentiment of a number of witnesses, advising the Subcommittee that "the magnitude of our cost problems and their solution requires a Federal commitment to a program of national health care to protect all Americans from devastating health care costs." Only a program of such scope and commitment is capable of stemming the tide of increasing medical care costs and finally making access to and equity in health care delivery a reality for all Americans.

Anything short of a major, overarching initiative will be like "squeezing the balloon or the pillow at each point," according to Robert Evans. This position was corroborated by Daniel Dragalin who reminded the Subcommittee that:

> As pressure is exerted on one part of the health care system, as it was on hospital services, there is a tendency for expenditures to go up in other, less regulated sectors. . . . The introduction of the prospective payment system resulted in many services being moved outside the hospital . . . [resulting in] a 38.5 percent rise in Medicare Part B (physician services) premiums last year.

Dorothy Rice similarly noted that piecemeal approaches and stopgap measures to hold down medical costs simply do not work. They simply shift the burden from one population to another and from one payer to another. As Paul Ginsburg concluded, "quick and simple solutions to the problem of rising costs for physician services do not exist."

It is not merely the financing of the system that will be corrected by national health insurance. A national health policy and program, Dr. Perry advised, would introduce a more orderly process of health care delivery.

Few health care problems, for example, are as costly or protracted as long-term care for the elderly. Witnesses described a situation in which Medicaid patients must often wait months for admittance to long-term care facilities; once admitted, differential treatment is frequently provided to private and Medicaid patients because of the differential reimbursement to the facility; and large numbers of private paying patients become impoverished paying their health care bills before qualifying for Medicaid.

Ms. Moon of AARP and Mr. Wiener of The Brookings Institution endorsed a social insurance program which would provide universal coverage for long-term care. Mr. Wiener suggested that everyone should contribute to the long-term care insurance and earn the right to benefits when they need them without having to prove impoverishment. He estimates that such a program would cost from $38 billion to $47 billion, compared with $20 billion under current policies. A payroll tax of 2.4 percent to 3.1 percent, half on employers and half on employees, would be required to finance the program.

Karen Davis explained that Medicaid is an example of a program that has instituted effective cost containment measures. However, this has occurred at the expense of other important objectives, such as assuring access to quality health care for the poor and assuring patients the opportunity to choose their own physician. Equity and access remain elusive goals for U.S. health care policy. Jack Owen of the American Hospital Association, testified that "ensuring access to adequate health care services continues to be the No. 1 challenge facing . . . our health care delivery system." Thus, Ms. Moon urged that a publicly financed program of national health insurance would help to spread costs in a more affordable manner across the population while assuring all citizens access to care.

Because of the similarities in our culture and values, several witnesses pointed to the Canadian experience of national health insurance, which has successfully moderated health care cost increases, as a model for the United States. Mr. Evans described the origins of the Canadian approach. Instead of the American approach of selecting certain categories of people to cover, the Canadians provided entire classes of service universally all at once. Once they successfully went universal for one sector, they expanded to the next.

Both hospitals and physicians are fee-for-service, but the fee is paid by the provincial government according to fee schedules, negotiated annually between the provincial government and the physicians' organization. Finally, the entire system is funded with tax revenues.

Mr. Evans concludes that health care costs are not dictated by national income, the overall structure of technology or the demographics of the population. He states unequivocally that:

1. Universal coverage *is the means* for getting costs under control; and
2. There is no tradeoff between universal coverage and cost control—the two are complimentary.

Medicare Reform

It seems obvious that to be successful, reform solutions must involve the active participation and cooperation of physicians and physician organizations in the development of acceptable approaches. For this reason, among others, national health insurance may be a long way from becoming a reality in the United States. Medicare reform, however, seems somewhat more achievable. Since Medicare accounts for 20 percent of the payments to physicians and almost 30 percent to hospitals, and since Medicare practices tend to be adopted by the rest of the health care system, reforming

Medicare payments and procedures seems to offer a viable avenue for reforming our health care delivery system.

The predominant method of physician payment in the United States, fee-for-service, has the potential to limit costs. However, as it is presently utilized, with physicians setting the fees, fee-for-service is terribly complex and inflationary. An overhaul of this payment method would go a long way toward curbing the Nation's soaring health care costs.

Fee Schedule

There are those who argue that a fee schedule should be designed for Medicare health care system and that the development of a fee schedule would provide a much more efficient and effective basis for carrying on purchaser-provider negotiations and strengthening competitive market forces. It has been argued that rather than being anticompetitive, such negotiations would lead toward a more competitive physician service market because it would eliminate the current CPR/UCR system which is "an unwieldy and inefficient basis for reaching physician-payer price agreements," according to Lynn Etheredge.

To minimize the complexity and high cost of the current system, Mr. Ginsburg advised the Subcommittee, the Physician Payment Review Commission has designed a fee schedule that would correct many of the deficiencies in the existing Medicare payment system. Mr. Ginsburg described this fee schedule for the Subcommittee. The relative value scale (RVS) would be based on the resource costs of providing services. These costs include physicians' own time and effort and their costs of practice, e.g., rent, staff salaries, and malpractice insurance premiums.

An RVS based on resource costs, according to Mr. Ginsburg, "would promote a more appropriate and efficient allocation of medical services and should generally be seen by physicians as more equitable."

Karen Davis argues that fee schedules are only partially the answer. To be effective in moderating cost increases, she insists, annual increases in the fee schedule must be pegged to performance on physician expenditures. Expenditure targets should be established, such as limiting increases in Medicare physician expenditures to increases in the size of GNP. Further, physicians should be required to accept the allowed fee as payment in full and not be permitted to charge patients fees in excess of the allowable fee. In 1987, this amounted to $2.5 billion.

Preferred Provider Organizations

Another health care cost effort currently underway is the Health Care Finance Agency's Preferred Provider Organizations (PPOs) discussed by Dr. Dragalin. Under this approach, physicians who practice "conservative medicine," defined as meeting cost, volume, and quality expectations, would be sought out by Medicare beneficiaries. The beneficiaries who use PPOs would pay a smaller share of the bill than those who do not. Currently, the beneficiary may pay 20 percent of a physician's bill.

Appropriate Use of Technology

The overuse of technology is another seemingly intractable problem in the health care field which contributes significantly to the rapid increase in health care costs. Undoubtedly, the use of high-technology equipment and treatments have contributed mightily to the quantity of health care in this country. However, while some use of technology produces great benefit, at other times the use of certain procedures and treatments may produce no benefit or may even have a negative effect.

Witnesses expressed very strong sentiment that the use of technology must be managed more efficiently. Witnesses testified that, often, as soon as new technology is made available, it is utilized—often, irrespective of whether it is necessary—and, often in conjunction with existing technology which may be obsolete but is still in use. Physicians and patients must be aware of the costs and likely benefits of tests and treatments.

Treatment Guidelines

Joseph Califano told the Subcommittee that even when most doctors agree that certain treatments are appropriate, there is still enormous variation in the rates at which people living in different places are subjected to certain procedures. To overcome this problem, witnesses suggested that standards of care should be developed and applied. It was agreed that establishing clear treatment guidelines could lead to reduced costs with no reduction in quality. This involves a concerted, systematic effort to increase medical professional consensus about whether, when, and how to treat. Mr. Califano cautioned, however, that one of the most complex tasks facing the health care providers is finding out what procedures truly have an impact on a patient's condition because the science of quality measurement is still in its infancy.

Andrew Webber, Executive Vice President, American Medical Peer Review Association, suggested four assessment tools, vital to the process. They are:

1. Integrated databases: This is the ability to track both the utilization and outcome of medical care services across all types of care. This would include common integrated cost accounting nationwide and for all providers. Significant investments are needed to permit this procedure to be carefully undertaken.

2. Objective clinical data: This is the need to collect routinely more objective clinical data on a patient's physiological condition prior to, during, and after medical intervention. Such data would permit the classification of patients, not by diagnosis, but by severity of illness. This would permit more objective analysis of clinical performance and would also permit more equitable provider reimbursement.

3. Longitudinal outcome studies: These studies track the risks and benefits of various types of treatment. They are needed to decide questions of medical efficacy. Well-funded, controlled, clinical trials are needed to evaluate outcomes for like patients who do, and do not, receive treatment. In addition, various approaches to actual treatment need to be measured against patient outcomes.

4. Clinical guidelines/standards: The results of outcome research can be fed back to the medical profession and form the basis for the establishment of clinical guidelines for both when and how to treat.

Mr. Webber cautioned that treatment guidelines must be used by local physician-based review organizations and should not be applied to payment decisions by payers. Further, he argued, physicians must maintain the flexibility to deviate from the norm when medical judgment dictates a different course of action. This freedom cannot be restricted by the arbitrary and strict application of clinical standards.

Patient Attitudes

In addition to developing guidelines to curb overuse of technology, witnesses indicated that patients will have to be willing to forgo services of little or no benefit. Patients tend to associate procedures with cures and, therefore, have a preference for medical intervention. Physicians generally are all too willing to satisfy this need. Patients must, therefore, be taught that more is not better. They must be taught to question physicians about procedures; they must be reeducated to look beyond how much physicians do *to* them and ascertain, instead, how much the procedure will do *for* them. One way to begin this process, suggested by Mr. Califano, is to pay doctors to talk to their patients and to persuade patients that fees for counseling are often better spent than those paying only for doctors to "do something" to them.

Research Needs

Joseph Califano urged that we *"dramatically reorder our research priorities."* We must, he advised the Subcommittee, direct money for medical research to one of our largest problems—aging. Mr. Califano called for the creation of a Project Independence for Older Americans. This effort would be aimed at reducing and eliminating the chief threats to the independence of the elderly: incontinence, memory loss, and immobility.

Although annual health care costs for patients afflicted with these three diseases are about $60 billion and rising sharply, only about $200 million—one-third of 1 percent of total health care costs—is spent on research to cure or eliminate them. Yet, attaining independence for the elderly would go a long way toward curbing the enormous increase anticipated in future health care costs. Each reduction of one month in the average period of dependence means an annual savings for our country of up to $4 billion.

Health Prevention

The costs of preventable illness in the United States are enormous. James A. Harrell, Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Public Health Service, reports that in 1980 the estimated economic cost of preventable heart disease and stroke was more than $100 billion; the cost of preventable cancer was $50 billion; and preventable accidents, $82 billion.

Nearly 60 percent of all deaths that occur each year in the United States are premature, and a similarly high proportion of disability and illness could be avoided. Preventable risk factors are known for cardiovascular disease, cancer, stroke, and injuries. These categories alone account for almost three-quarters of American deaths each year.

Additional research into the effectiveness of health promotion and disease prevention programs would be both beneficial to the Nation's health status and cost effective. Yet, at best, only 4 percent of national health care dollars are spent on health promotion and disease prevention (including counseling) and this figure could be as low as 0.3 percent.

Mr. Califano cited specific priorities which ought to be adopted to reduce our health care costs both human and economic. Americans, he urged, must be encouraged to stop smoking, control drinking, stick to a proper diet, take regular exercise, learn to handle stress, practice preventive care, and have regular checkups.

The Elderly

Dr. Pawlson stressed the need for preventive measures to reduce elderly health care needs. Dr. Pawlson suggested that "we have not invested even the minimal research dollars necessary to determine the efficacy and cost effectiveness of most preventative measures." He suggested that, "many older persons, and sadly many of their physicians, feel that preventative measures are of little or no use for older persons." Dr. Pawlson argues, however, that because of the limited ability to respond to disease, prevention may be the only effective intervention in some situations involving older persons. For instance, a screening test for colon and breast cancer and use of vaccines for flu and pneumonia prevention may be more cost effective for the elderly than for younger populations, he asserted. Yet, the fact that Medicare does not reimburse for most preventive services which, Dr. Pawlson charges, is "shortsighted and costly."

Not all the efforts required to improve the health of the elderly are intimidating by their sheer scope or cost. T. Franklin Williams, M.D., Director, National Institute on Aging, recommended that we go forward with an all-out effort to inform the public about lifestyle changes which can improve health status, even of the elderly. For instance, an exercise regimen can be started at virtually any age and prove beneficial to most people; cessation of smoking at any age can halt the progressive loss of lung function; and good nutrition, as well as reducing alcohol and drug intake can have a positive effect on the physical and social well-being of older people.

In addition, Mr. Harrell urged that teen pregnancies must be reduced. To accomplish the Nation's preventive goals, he urged:

1. Additional research into the effectiveness of health promotion and disease prevention programs;
2. More attention to prevention by health care providers;
3. A deeper commitment by employers and workers to worksite health promotion; and
4. Comprehensive school health programs for children and stronger emphasis on helping older citizens maintain their independence and well-being.

Care of the Elderly

One of the most critical challenges facing our health care system, according to Dr. Pawlson, is the way in which we organize and utilize services in the care of the frail elderly. Because this segment of the population will be increasing so dramatically in the next several decades and the costs of long-term care is so high, he urges that action is needed now to improve the efficiency and effectiveness of long-term care. Given our demographic mix and the exorbitant cost of long-term care, if the need for and costs of long-term care are not reduced, we are likely to compromise our future economic position in the world economy. Our escalating health care costs will force us, as a nation, to sacrifice commitments in education, research and development, and science to pay our health care bill. In addition to the need for research and altering lifestyles to foster health promotion and disease prevention, health care for the frail elderly needs to be restructured and options for private sector financing of long-term care should be considered.

Assessment and Management

Dr. Pawlson suggests that the basic elements of care for the frail elderly should include:

1. Geriatric assessment: This involves a careful and systematic review by a multidisciplinary group of health care professionals to determine medical diseases as well as social, psychological, and cognitive problems in the older person. This assessment is useful in devising a plan that best meets the needs of the individual patient. This process may reduce the length of stay in acute hospitals and the long-range use of nursing homes as well as improving functional outcomes.

2. Management of care in an organized and coordinated fashion with emphasis on rehabilitation and maintenance of function. Our current system of isolated, fragmented services, with little linkage between physicians, nurses, and social workers, is ineffective and wasteful. More support for research and demonstration projects involving innovations in long-term care are essential if we are to meet the challenges we face in the future.

Private Sector Role

Joshua Weiner sees a role for the private sector in long-term care. Although he concludes it is unrealistic to expect the private sector to play a much greater role in financing long-term care, he suggests a number of options:

1. Creation of Individual Medical Accounts (IMAs): IMAs would increase incentives for savings earmarked for long-term care. IMAs would receive favorable tax treatment;

2. Increasing the ability of older people to use the equity accumulated in their home to pay for long-term care through home equity conversions;

3. Establishment of continuing care retirement communities for older people and guaranteed care for residents;

4. Formation of social/health maintenance organizations which are extensions of HMOs to include long-term care; and

5. Pooling the risk of high long-term care expenses through private long-term care insurance.

Rationalizing Malpractice Liability

Changes/Alternatives to the Current System

Witnesses discussed a variety of options for overhauling the current system of medical malpractice adjudication, which fall into the following two categories:

1. Reforms to improve administration of the current judicial system, including propoals to set rules for calculating damages.
2. Substitution of administrative boards, rules or "alternative dispute resolution" (ADR) mechanisms (e.g., arbitration), for the courts.

Traditional Tort/Judicial Reform

Randall R. Bovbjerg, Senior Research Associate at the Urban Institute, suggested that the following types of reforms could contribute to improving administration of the current judicial system:

- Clearer and more precise instructions to juries.
- Increased reliance on jury interrogatories (i.e., allowing lawyers to summarize evidence on their side of the case rather than calling a long procession of witnesses to the stand).
- Requirement for unanimous 12-person jury verdicts.
- Creation of new computer data banks showing amounts awarded in similar cases to guide juries and judges in setting awards.

Mr. Bovbjerg suggested that the following reforms could enhance the predictability, consistency, and equity of damage awards, and, hence, reduce the risk component of malpractice premiums:

- Relying on a formula or other standardized method for computing the amount of awards in certain cases.
- Structuring awards as periodic payments instead of as lump-sum payments, as in Indiana and California.

Other witnesses emphasized that reforms aimed at making the current system more efficient address only part of the problem. Mr. Hoff, for example, stressed the importance of reducing the amount of litigation. And while limiting awards and attorney's fees can reduce somewhat the incentive to litigate, it remains unclear whether such reforms significantly lessen the amount of litigation.

Administrative Reforms

Witnesses urged that medical malpractice disputes be settled in administrative forums by using no-fault insurance plans or through mediation, arbitration, and other out-of-court procedures. Providing financial incentives for alternatives to litigation before the fact could induce plaintiffs to utilize this approach. Using administrative forums would radically reduce the resources consumed in costly litigation. It would also provide greater access to the system as some injured patients are unable to seek redress through the current system because of the high cost.

Ethical Issues

The Federal Role

Although some of the most important steps in minimizing ethical questions involve individual actions, such as drafting a "living will" and providing for "durable power of attorney for health care," there is also a role for the Federal Government in helping to address these increasingly common and difficult issues. Witnesses urged that the Federal Government take action to the following areas to improve the clinical decisionmaking process:

- Increased funding for research;
- Promoting ethics education among medical professionals and enhancing patients' awareness of their options;
- Modifying Medicare to reimburse palliative care for the dying; and
- Setting Federal standards for advance directives which would recognize the legal right of such documents and simplify the requirements of their use.

FUNDING FOR RESEARCH AND ASSESSMENT

Citing the need to contain costs and to increase understanding of medical care, Mr. Abram urged the Federal Government to fund research on the appropriateness and effectiveness of diagnostic and therapeutic procedures to determine what works under what combination of circumstances.

There is also a dearth of information on the impacts of alternative treatments on the patient's quality of life. Better information on this area is crucial to informed decisionmaking by patients.

In addition, Joanne Lynn, of the Center for Aging Studies and Services, George Washington University, urged that the Federal Government take the lead on how decisions should be made for incompetent patients who have not executed advance directives.

EDUCATIONAL/INFORMATIONAL ROLE

Witnesses agreed that the Federal Government should continue to take the lead in the ethics debate by holding hearings, issuing reports, and funding commissions, such as the President's Commission on Biomedical Ethics.

Dr. Lynn suggested that the Federal Government use its vast regulatory powers and financial leverage to promote ethical education among current and would-be medical practitioners, in the following ways:

- Providing loans only to medical students attending institutions that teach medical ethics in decisionmaking;
- Mandating the teaching of ethics in Veterans' Administration and Defense Department institutions; and
- Requiring the teaching of ethics in residency programs supported by Medicare.

In addition, Mr. Scofield of Concern for Dying, suggested that the Federal Government require residency training programs to educate physicians regarding the law on the patient's right to refuse or withdraw from treatment.

Ms. Wolf of the Hastings Center testified that the Federal Government could also spur greater awareness of the ethical concerns involved in life-sustaining treatment by requiring all hospitals to formulate explicit policies on how they deal with terminally ill and incapacitated patients as a condition for participation in Medicare.

Witnesses pointed out a number of situations in which it would be appropriate to raise advance planning issues with individuals, such as when consulting with a physician on a given condition or upon admission to hospitals or nursing homes. Dr. Lynn suggested that health-care providers could be encouraged to inform patients about advance directives (living wills or power of attorney) by reimbursing the costs of this service through Medicare.

MEDICARE RULES

Several witnesses noted that current Medicare reimbursement rules do not permit payment for physician consultations and counseling with patients and their families, as described elsewhere in this report. As a result, according to Mr. Abram:

> . . . we have built perverse incentives into the health-care system. We pay doctors only for doing something to us. Since doctors are paid for procedures, they conduct many procedures.

Hearing witnesses advocated the following measures to address these issues:

- Amend Medicare reimbursement rules to provide for physician consultations/counseling to remove the financial incentive for doctors to perform procedures when none are necessary, as proposed by Ms. Wolf and Dr. Lynn.
- Change Medicare policies to provide explicitly for the reimbursement of palliative care as suggested by Dr. Lynn.

Another change to Medicare regulations suggested by Dr. Lynn is refusing to pay for hospital care which is prolonged by hospitals seeking court orders where physicians and family are in agreement to terminate a patient's life-support system.

AGENDA AND WITNESS LIST

Subcommittee on Education and Health
of the Joint Economic Committee of Congress
James H. Scheuer, Chairman

HEARING ON THE FUTURE OF HEALTH CARE IN AMERICA

May 3, 1988

TOPIC: TRENDS IN U.S. AND INTERNATIONAL HEALTH CARE COSTS

Joseph A. Califano, Jr., Former Secretary, U.S. Department of Health, Education and Welfare.

Daniel Waldo, Economist (accompanied by Mark Freeland), Health Care Financing Administration, U.S. Department of Health, Education and Welfare.

Karen Davis, Professor and Chairman, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health.

Dorothy P. Rice, Professor, Institute of Health and Aging, University of California at San Francisco.

George J. Schieber, Director, Office of Research, Health Care Financing Administration, U.S. Department of Health and Human Services.

George A. Silver, M.D., Emeritus Professor of Public Health, Yale University School of Medicine.

Uwe E. Reinhardt, James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University.

Robert G. Evans, Professor of Economics, University of British Columbia.

May 10, 1988

TOPIC: TRENDS IN U.S. POPULATION AND HEALTH STATUS

Michael C. Carozza, Deputy Commissioner for Policy and External Affairs (accompanied by Harry C. Ballantyne, Chief Actuary), Social Security Administration.

John G. Keane, Director (accompanied by Cynthia Taeuber, Chief of Age and Sex Statistics Branch, Population Division), Bureau of the Census, U.S. Department of Commerce.

Robert A. Binstock, Henry B. Luce Professor of Aging, Health and Society, School of Medicine, Case Western Reserve University.

James W. Vaupel, Director, Center for Population, Analysis and Policy and Professor of Public Affairs, Hubert H. Humphrey Institute, University of Minnesota.

James A. Harrel, Deputy Director, Office of Disease Prevention and Health Promotion, Public Health Service, U.S. Department of Health and Human Services.
Margaret C. Heagarty, M.D., Director of Pediatrics, Harlem Hospital Center.
Jacob J. Feldman, Associate Director for Analysis and Epidemiology, National Center for Health Statistics, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services.
Lois M. Verbrugge, Associate Research Scientist, Institute of Gerontology, University of Michigan.

Tuesday, May 17, 1988

TOPIC: PAYMENT SYSTEMS FOR PHYSICIANS

Lynn Etheredge, Consultant, Consolidated Consulting Group.
Paul B. Ginsburg, Executive Director, Physician Payment Review Commission.
Joseph T. Painter, M.D., Member, Board of Trustees, American Medical Association (accompanied by Bruce D. Blehart, Director Department of Federal Legislation A.M.A.).
Daniel Dragalin, M.D., Vice President, Group Medical Services, The Prudential Insurance Company of America.
Andrew Webber, Executive Vice President, American Medical Peer Review Association.

May 19, 1988

TOPIC: PAYMENT SYSTEMS FOR HOSPITALS

Gerard F. Anderson, Director, Center for Hospital Finance and Management, Johns Hopkins University.
Donald Young, M.D., Executive Director, Prospective Payment Assessment Commission.
Jack Owen, Executive Vice President, American Hospital Association.
Susan Gleeson, Executive Director, Technology/Management Department, Blue Cross and Blue Shield Association.
Carl Schramm, President, Health Insurance Association of America.
Annette Choolfaian, Executive Vice President, St. Luke's Roosevelt Hospital Center.

May 24, 1988

TOPIC: THE CHANGING NATURE OF MEDICAL TECHNOLOGY

Clyde Behney, Health Program Manager, Office of Technology Assessment, U.S. Congress.
Seymour Perry, M.D., Deputy Director, Institute for Health Policy Analysis, Georgetown University Medical Center.
Stanley J. Reiser, M.D., Griff T. Ross Professor of Humanities and Technology in Health Care, University of Texas Health Science Center.
Jack D. Meyers, M.D., University Professor Emeritus in Medicine, University of Pittsburgh.

Homer R. Warner, M.D., Professor and Department Chairman, Department of Medical Informatics, University of Utah.
Jerome H. Grossman, M.D., President and Chief Executive Officer, New England Medical Center Hospitals, Inc.
Melroy D. Quasney, Associate Director, Information Management and Technology Division, U.S. General Accounting Office.

June 14, 1988

TOPIC: HEALTH CARE NEEDS OF THE ELDERLY

Jacob A. Brody, M.D., Dean, School of Public Health, University of Illinois at Chicago.
T. Franklin William, M.D., Director, National Institute on Aging, National Institutes of Health.
L. Gregory Pawlson, M.D., Director, Center for Aging Studies and Services and Chairman, Department of Health Care Sciences, George Washington University.
Joshua M. Wiener, Senior Fellow, Brookings Institution.
John Holahan, Director and Korbin Liu, Senior Research Associate, Health Research Policy Center, The Urban Institute.
Marilyn Moon, Director, Public Policy Institute, American Association of Retired Persons.
Gerald M. Eggert, Executive Director, Monroe County Long Term Care Program, Inc./Access, East Rochester, New York.

June 16, 1988

TOPIC: INNOVATIVE APPROACHES TO HEALTH CARE DELIVERY

Philip W. Johnston, Secretary (accompanied by Karen Smith, Massachusetts Health Policy Office), Massachusetts Department of Human Services.
Ernest J. Sessa, Executive Director, Pennsylvania Health Care Cost Containment Council.
Linda Hill-Chinn, Director, Community Programs for Affordable Health Care.
Stephen A. Somers, Senior Program Officer, The Robert Wood Johnson Foundation.
Richard Wardrop, Director, Health Cost Management, Aluminum Company of America.
Lee Saunders, Assistant Director of Research, American Federation of State, County and Municipal Employees.

June 21, 1988

TOPIC: ETHICAL PROBLEMS IN HEALTH CARE

Morris B. Abram, Attorney, Paul, Weiss, Rifkind, Wharton & Garrison, Member, National Leadership Commission on Health Care.
Susan M. Wolf, Associate for Law, Hastings Center.
Giles R. Scofield, III, Staff Counsel, Concern for Dying.
Ann Neale, Vice President, Mission Bon Secours Health System, Inc.
Joanne Lynn, M.D., Acting Director, Center for Aging Studies, George Washington University.

Nancy Coleman, Director, Commission on Legal Problems of the Elderly, American Bar Association.
Allan D. Bogutz, Attorney, Bogutz and Gordon, P.C.

TOPIC: MEDICAL MALPRACTICE

Roger J. Bulger, M.D., Chairman (accompanied by Victoria P. Rostow, Director), Medical Professional Liability Study, Institute of Medicine, National Academy of Sciences.
Carter G. Phillips, Attorney, Sidley & Austin and Legal Consultant, AMA/Specialty Society Medical Liability Project.
Randall R. Bovbjerg, Senior Research Associate, The Urban Institute.
Thomas B. Metzloff, Associate Professor, Duke University School of Law.
Laurence R. Tancredi, M.D., Director, Health Law Program, University of Texas Health Science Center at Houston.
John S. Hoff, Legal Counsel, National Council of Community Hospitals.

June 23, 1988

TOPIC: HEALTH CARE NEEDS IN THE 21ST CENTURY

C. Everett Koop, M.D., Surgeon General, Public Health Service, U.S. Department of Health and Human Services.
David Axelrod, M.D., Commissioner, New York State Department of Health.
Robert D. Ray, President, National Leadership Commission on Health Care and President, Life Investors Insurance Company of America.
Paul G. Rogers, former Chairman, Health and Environment Subcommittee of the Interstate and Foreign Commerce Committee of the U.S. Congress and Cochairman, National Leadership Commission on Health Care.
William F. Raub, Deputy Director, National Institutes of Health, U.S. Department of Health and Human Services.
Edmund J. McTernan, Sr., Professor and Dean, School of Allied Health Professions, State University of New York at Stony Brook.

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